IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

Blue Cross and Blue Shield of Georgia, Inc.; Blue Cross of California, Inc. d/b/a/ Anthem Blue Cross; Anthem Blue Cross Life and Health Insurance Company; Rocky Mountain Hospital and Medical Service, Inc. d/b/a Anthem Blue Cross and Blue Shield; Anthem Health Plans, Inc. d/b/a Anthem Blue Cross and Blue Shield; Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.; Anthem Insurance Companies, Inc. d/b/a Anthem Blue Cross and Blue Shield; Anthem Health Plans of Kentucky, Inc. d/b/a Anthem Blue Cross and Blue Shield; Anthem Health Plans of Maine, Inc. d/b/a Anthem Blue Cross and Blue Shield; RightCHOICE Managed Care, Inc.; Healthy Alliance Life Insurance Company; HMO Missouri, Inc.; Anthem Health Plans of New Hampshire, Inc. d/b/a Anthem Blue Cross and Blue Shield; Empire HealthChoice Assurance, Inc. d/b/a Empire Blue Cross and Blue Shield; Community Insurance Company d/b/a Anthem Blue Cross and Blue Shield; Anthem Health Plans of Virginia, Inc. d/b/a Anthem Blue Cross and Blue Shield; HMO	**THIRD AMENDED COMPLAINT** JURY TRIAL DEMANDED Civil Action No.: 1:18-cv-01304-MLB

Healthkeepers, Inc. d/b/a Anthem Blue Cross and Blue Shield; Blue Cross Blue Shield of Wisconsin d/b/a Anthem Blue Cross and Blue Shield; Compcare Health Services Insurance Corporation d/b/a Anthem Blue Cross and Blue Shield; Blue Cross Blue Shield of Michigan Mutual Insurance Company; BCBSM, Inc. d/b/a BlueCross BlueShield of Minnesota; Regence BlueCross BlueShield of Oregon; Regence BlueCross BlueShield of Utah; Regence BlueShield; and Regence BlueShield of Idaho, Plaintiffs, v. DL Investment Holdings, LLC f/k/a Durall Capital Holdings, LLC d/b/a Chestatee Regional Hospital, Reliance Laboratory Testing, Inc., Medivance Billing Serv., Inc., Aaron Durall, Jorge Perez, and Neisha Carter Zaffuto, Defendants.	

Plaintiffs Blue Cross and Blue Shield of Georgia, Inc. ("BCBS Georgia"); Blue Cross of California, Inc. d/b/a/ Anthem Blue Cross; Anthem Blue Cross Life and Health Insurance Company; Rocky Mountain Hospital and Medical Service, Inc. d/b/a Anthem Blue Cross and Blue Shield; Anthem Health Plans,

Inc. d/b/a Anthem Blue Cross and Blue Shield; Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.; Anthem Insurance Companies, Inc. d/b/a Anthem Blue Cross and Blue Shield; Anthem Health Plans of Kentucky, Inc. d/b/a Anthem Blue Cross and Blue Shield; Anthem Health Plans of Maine, Inc. d/b/a Anthem Blue Cross and Blue Shield; RightCHOICE Managed Care, Inc.; Healthy Alliance Life Insurance Company; HMO Missouri, Inc.; Anthem Health Plans of New Hampshire, Inc. d/b/a Anthem Blue Cross and Blue Shield; Empire HealthChoice Assurance, Inc. d/b/a Empire Blue Cross and Blue Shield; Community Insurance Company d/b/a Anthem Blue Cross and Blue Shield; Anthem Health Plans of Virginia, Inc. d/b/a Anthem Blue Cross and Blue Shield; HMO Healthkeepers, Inc. d/b/a Anthem Blue Cross and Blue Shield; Blue Cross Blue Shield of Wisconsin d/b/a Anthem Blue Cross and Blue Shield; Compcare Health Services Insurance Corporation d/b/a Anthem Blue Cross and Blue Shield; Blue Cross Blue Shield of Michigan Mutual Insurance Company; BCBSM, Inc. d/b/a BlueCross BlueShield of Minnesota; Regence BlueCross BlueShield of Oregon; Regence BlueCross BlueShield of Utah; Regence BlueShield; and Regence BlueShield of Idaho (collectively, "Plaintiffs") by and through the undersigned counsel, hereby file this Complaint against Defendants DL Investment Holdings, LLC, which does business as Chestatee Regional

Hospital, and was formerly known as Durall Capital Holdings, LLC ("Chestatee" or "Durall Capital"),[1] Reliance Laboratory Testing, Inc. ("Reliance Labs"), Medivance Billing Service, Inc. ("Medivance"), Aaron Durall, Jorge Perez, and Neisha Carter Zaffuto (collectively, "Defendants").

Plaintiffs further state and allege as follows:

NATURE OF THE ACTION

1. Since 2016, Defendants have engaged in a widespread fraudulent scheme to enrich themselves at Plaintiffs' expense by billing for laboratory services that were not payable, were fraudulent, were in violation of contracts between BCBS Georgia and Chestatee Regional Hospital, and were unlawful.

2. Chestatee Regional Hospital is a 49-bed hospital located in Dahlonega, Georgia.

3. Until August 2016, Chestatee Regional Hospital was owned by Southern Health Corporation of Dahlonega.

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[1] "Chestatee" and "Durall Capital" refer to Defendant DL Investment Holdings, LLC f/k/a Durall Capital Holdings, LLC, the entity that acquired Chestatee Regional Hospital in August 2016 and does business under that name. Where used, "Durall Capital" refers to this entity prior to its acquisition of Chestatee Regional Hospital.

"Chestatee Regional Hospital" refers to the hospital in Dahlonega, Georgia, including prior to its purchase by Durall Capital or when distinguishing between the off-site operations of Durall Capital (in Florida) and the on-site operations of the hospital (in Georgia) after the acquisition.

4. BCBS Georgia's relationship with Southern Health Corporation of Dahlonega was governed by three contracts. The contracts made Chestatee Regional Hospital an in-network provider in BCBS Georgia's provider network and established the rates at which BCBS Georgia would reimburse Chestatee Regional Hospital for the provision of medically necessary services to enrollees of health plans offered by BCBS Georgia and its affiliates.

5. In August 2016, Durall Capital purchased Chestatee Regional Hospital for $15 million.

6. BCBS Georgia allowed Southern Health Corporation of Dahlonega to assign its rights, duties, and obligations under the contracts to Durall Capital.

7. Unbeknownst to BCBS Georgia, as soon as Durall Capital took control of Chestatee Regional Hospital, Durall Capital agreed with Reliance Labs, an out-of-network toxicology laboratory located in Sunrise, Florida, to fraudulently bill BCBS Georgia for tests performed at and by Reliance Labs as if the tests had been performed at and by Chestatee Regional Hospital.

8. When providers ordered the tests, they ordered them from Reliance Labs, not from Chestatee Regional Hospital.

9. Providers shipped their patients' specimens to Reliance Labs' facility in Florida, not to Chestatee Regional Hospital's facility in Georgia.

10. Reliance Labs performed the tests in Florida and reported the results to providers through a Reliance Labs online portal.

11. After testing the patient specimens, Reliance Labs sent some of them to hospitals controlled by Aaron Durall, including Chestatee. The hospitals tested some portion of the specimens, but the tests provided no clinical value because (a) they were less sophisticated than the tests already conducted on the specimens at Reliance Labs and (b) providers received test results from Reliance Labs, not from the hospitals. Upon information and belief, the specimens were re-tested at the hospitals to make it appear as though the hospitals were more involved in the testing than they actually were.

12. Chestatee, Reliance Labs, Aaron Durall, and the other Defendants billed the tests to Plaintiffs through Chestatee because BCBS Georgia's contracts with Chestatee entitled it to substantially more than Reliance Labs would receive for tests that it performed.

13. Aaron Durall is the President of Reliance Labs, the Chief Executive Officer of Chestatee, and the Manager of Durall Capital. He arranged for Durall Capital's acquisition of Chestatee Regional Hospital, and caused Chestatee and Reliance Labs to act together in furtherance of this fraudulent scheme.

14. Aaron Durall and Chestatee engaged Defendant Jorge Perez to assist in the management of the scheme.

15. Aaron Durall, Chestatee, and Reliance Labs engaged Medivance to handle billing, medical records, and collections. Medivance submitted the claims to Plaintiffs on behalf of the other Defendants.

16. Neisha Carter Zaffuto is President of Medivance and oversaw and directed the submission of the claims to Plaintiffs.

17. The Defendants conspired to bill Plaintiffs for the tests as if they had been ordered from and performed by Chestatee, when in fact they were ordered from and performed by Reliance Labs. The conspiracy was designed to take advantage of Chestatee's in-network status and favorable reimbursement rates.

18. The tests at issue are predominantly for urine-drug testing, but also include other forms of testing.

19. The Defendants' scheme is known as "pass-through billing."

20. The Defendants leveraged a nationwide network of providers and laboratories who referred their patients' specimens. Some providers provided patients' specimens in exchange for a cut of the amount that Chestatee was reimbursed by Plaintiffs.

21. The patients were never present at Chestatee, were never treated by Chestatee-credentialed providers, and were often in treatment hundreds or thousands of miles from Chestatee. Their only connection to Chestatee was that the Defendants billed their tests through the hospital in order to misuse Chestatee's in-network status and reimbursement rate.

22. If Reliance Labs billed the tests directly to Plaintiffs, many would not have been paid. Any tests that were paid would have been paid at materially lower rates.

23. The increased volume of urine-drug testing claims billed by Chestatee because of this scheme is staggering. Specifically, in the year before the Defendants implemented their scheme, Chestatee billed about 30 urine-drug testing claims per month to BCBS Georgia. In the year after the Defendants implemented their scheme, Chestatee billed an average of about 4,800 urine-drug testing claims per month to BCBS Georgia (an increase of 16,000%).

24. Urine-drug testing also became the majority of the claims that Chestatee submitted to BCBS Georgia. Specifically, between the start of the scheme and late 2017, Chestatee billed BCBS Georgia an average of $12.7 million per month for urine-drug testing, when it billed BCBS Georgia only about $1.2 million per month for *all other* hospital claims.

25. Defendants implemented the pass-through scheme even though they knew that the claims were not payable, were fraudulent, were in violation of Chestatee's contracts with BCBS Georgia, and were otherwise unlawful.

26. Plaintiffs seek compensation and equitable relief for the injuries that they have incurred because of Defendants' conduct. Plaintiffs also seek the imposition of punitive damages, and request injunctive relief (a) prohibiting Defendants from further perpetrating the scheme and (b) requiring Chestatee to comply with its contractual obligations to BCBS Georgia.

JURISDICTION AND VENUE

27. This Court has subject-matter jurisdiction over this action pursuant to 28 U.S.C. § 1332, because the matter in controversy is in excess of $75,000, exclusive of interest and costs, and is between citizens of different states.

28. This Court also has subject-matter jurisdiction over this action pursuant to 28 U.S.C. § 1331, because Plaintiffs' claims arise under the Constitution, laws, or treaties of the United States.

29. The Court has supplemental jurisdiction over the state law claims pursuant to 28 U.S.C. § 1367, because the state law claims are so related to the claims within the Court's original jurisdiction that they form part of the same case or controversy under Article III of the United States Constitution.

30. Venue is proper in this District pursuant to 28 U.S.C. § 1391(b)(2) because a substantial part of the events or omissions giving rise to the claims asserted herein occurred in this District.

THE PARTIES

PLAINTIFFS

31. Plaintiff Blue Cross and Blue Shield of Georgia, Inc. is incorporated and headquartered in Georgia.

32. Plaintiff Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. is incorporated and headquartered in Georgia.

33. Plaintiff Blue Cross of California d/b/a Anthem Blue Cross is incorporated and headquartered in California.

34. Plaintiff Anthem Blue Cross Life and Health Insurance Company is incorporated and headquartered in California.

35. Plaintiff Rocky Mountain Hospital and Medical Service, Inc. d/b/a Anthem Blue Cross and Blue Shield, is incorporated and headquartered in Colorado.

36. Plaintiff Anthem Health Plans, Inc. d/b/a Anthem Blue Cross and Blue Shield is incorporated and headquartered in Connecticut.

37. Plaintiff Anthem Insurance Companies, Inc. d/b/a Anthem Blue

Cross and Blue Shield is incorporated and headquartered in Indiana.

38. Plaintiff Anthem Health Plans of Kentucky, Inc. d/b/a Anthem Blue Cross and Blue Shield is incorporated and headquartered in Kentucky.

39. Plaintiff Anthem Health Plans of Maine, Inc. d/b/a Anthem Blue Cross and Blue Shield is incorporated and headquartered in Maine.

40. Plaintiff RightCHOICE Managed Care, Inc. is incorporated in Delaware and headquartered in Missouri.

41. Plaintiff Healthy Alliance Life Insurance Company is incorporated and headquartered in Missouri.

42. Plaintiff HMO Missouri, Inc. is incorporated and headquartered in Missouri.

43. Plaintiff Anthem Health Plans of New Hampshire, Inc. d/b/a Anthem Blue Cross and Blue Shield is incorporated and headquartered in New Hampshire.

44. Plaintiff Empire HealthChoice Assurance, Inc. d/b/a Empire Blue Cross and Blue Shield is incorporated and headquartered in New York.

45. Plaintiff Community Insurance Company d/b/a/ Anthem Blue Cross and Blue Shield is incorporated and headquartered in Ohio.

46. Plaintiff Anthem Health Plans of Virginia, Inc. d/b/a/ Anthem Blue

Cross and Blue Shield is incorporated and headquartered in Virginia.

47. Plaintiff HMO HealthKeepers, Inc. d/b/a Anthem Blue Cross and Blue Shield is incorporated and headquartered in Virginia.

48. Plaintiff Blue Cross Blue Shield of Wisconsin d/b/a Anthem Blue Cross and Blue Shield is incorporated and headquartered in Wisconsin.

49. Plaintiff Compcare Health Services Insurance Corporation d/b/a Anthem Blue Cross and Blue Shield is incorporated and headquartered in Wisconsin.

50. Plaintiff Blue Cross Blue Shield of Michigan Mutual Insurance Company is incorporated and headquartered in Michigan.

51. Plaintiff BCBSM, Inc. d/b/a BlueCross BlueShield of Minnesota is incorporated and headquartered in Minnesota.

52. Plaintiff Regence BlueCross BlueShield of Oregon is incorporated and headquartered in Oregon.

53. Plaintiff Regence BlueCross BlueShield of Utah is incorporated and headquartered in Utah.

54. Plaintiff Regence BlueShield is incorporated and headquartered in Washington.

55. Plaintiff Regence BlueShield of Idaho is incorporated and

headquartered in Idaho.

DEFENDANTS

56. Defendant DL Investment Holdings, LLC f/k/a Durall Capital Holdings, LLC d/b/a Chestatee Regional Hospital, is a Florida limited liability company. Upon information and belief, all of the members of this entity are residents of Florida.

57. Defendant Reliance Laboratory Testing, Inc. is incorporated and headquartered in Florida. The company operates a toxicology laboratory in Sunrise, Florida.

58. Defendant Medivance Billing Service, Inc. is incorporated and headquartered in Florida. Its headquarters is located in Sunrise, Florida.

59. Defendant Aaron Durall is a Florida resident and an attorney admitted to practice in that state.

60. Defendant Neisha Carter Zaffuto is a Florida resident.

61. Defendant Jorge Perez is a Florida resident.

THE BCBS PLANS

THE BLUECARD PROGRAM

62. Plaintiffs are independent licensees (or subsidiaries of independent licensees) of the Blue Cross and Blue Shield Association ("BCBS Association").

63. Each Plaintiff is a participant in the BCBS Association's BlueCard program, which allows members of one licensee's health plans to obtain healthcare in another licensee's service area (e.g., where a member is traveling or living outside of their home plan's service area).

64. Chestatee is located in BCBS Georgia's service area. The claims at issue were billed by Defendants to BCBS Georgia.

65. BCBS Georgia then reconciled the cost of the services billed by Chestatee with the BCBS Association licensee responsible for each member.

66. As a result, each of the Plaintiffs was harmed by the fraudulent scheme alleged herein.

ASSIGNMENT OF LEGAL CLAIMS FOR MONEY OWED BY OTHER LICENSEES OF THE BCBS ASSOCIATION

67. Other independent licensees of the BCBS Association (who similarly participate in the BlueCard program) have been injured by this pass-through scheme in the same way as Plaintiffs.

68. As a result, the following licensees of the BCBS Association have assigned to BCBS Georgia their legal claims for money owed as a result of Defendants' pass-through-billing scheme (the "Assignor BCBS Plans"): (a) Blue Cross and Blue Shield of Alabama; (b) USAble Mutual Insurance Company d/b/a Arkansas Blue Cross and Blue Shield; HMO Partners, Inc. d/b/a Health

Advantage; (c) Blue Shield of California; (d) CareFirst of Maryland, Inc., CareFirst BlueChoice, Inc., CFA, LLC; Group Hospitalization and Medical Services, Inc.; (e) Blue Cross and Blue Shield of Florida, Inc.; (f) Health Care Service Corporation; (g) Hawaii Medical Service Association; (h) Highmark, Inc., Highmark West Virginia Inc., Highmark BCBSD Inc., and Highmark Choice Company; (i) Horizon Blue Cross Blue Shield of New Jersey; (j) Blue Cross and Blue Shield of Kansas, Inc.; (k) Blue Cross of Idaho Health Service, Inc.; (l) Independence Blue Cross, LLC; (m) Blue Cross and Blue Shield of Kansas City; (n) Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana; (o) Blue Cross and Blue Shield of Massachusetts, Inc.; (p) Blue Cross & Blue Shield of Mississippi, Inc.; (q) Blue Cross and Blue Shield of Nebraska; (r) Blue Cross and Blue Shield of North Carolina; (s) Noridian Mutual Insurance Company d/b/a Blue Cross Blue Shield of North Dakota; (t) Premera Blue Cross; (u) Blue Cross & Blue Shield of Rhode Island; (v) Blue Cross and Blue Shield of South Carolina; (w) BlueCross BlueShield of Tennessee; (x) Blue Cross Blue Shield of Wyoming; (y) Blue Cross and Blue Shield of Arizona, Inc.; and (z) Wellmark, Inc.

69. The assignments completed by the Assignor BCBS Plans state that each Assignor BCBS Plan "assigns and transfers to BCBS Georgia the rights, title

and interest to legal claims for money owed, to the extent permitted by applicable law, that [the Assignor BCBS Plan] may assert against any individual or entity, known or unknown, because of their participation in the Chestatee Pass-Through Scheme."[2]

70. Collectively, Plaintiffs and the Assignor BCBS Plans are referred to herein as the "BCBS Plans."

MANAGED CARE AND THE BCBS PLANS

71. The BCBS Plans are insurers and third-party claims administrators for group health plans that provide benefits to covered individuals and dependents.

72. The BCBS Plans may insure group health plans directly (the "Fully-Insured Health Plans"). For the Fully-Insured Health Plans, the BCBS Plans resolve claims and makes benefit payments from their own assets.

73. The BCBS Plans also provide administrative services to self-funded group health plans (the "Self-Funded Health Plans"). The BCBS Plans deliver these services pursuant to Administrative Services Agreements between the BCBS Plans and the group health plan's sponsor (usually an employer), which identify the rights and obligations of each party. Many of the group health plans

[2] BCBS Assignor Plan Wellmark, Inc. restricted its assignment to its self-funded plans.

sponsored by private employers are governed by ERISA, 29 U.S.C. § 100 *et seq*. The BCBS Plans provide insurance and/or administrative services to these employer-sponsored group health plans, including the processing of claims for reimbursement of medical services provided to the individuals covered by these benefit plans.

74. The BCBS Plans paid claims to Chestatee for Self-Funded Health Plans, and seek redress in this lawsuit for those Self-Funded Health Plans.

75. The BCBS Plans' agreements with their customers expressly give the BCBS Plans authority and discretion to recover overpayments on behalf of their customers.

76. Accordingly, the BCBS Plans have authority and standing to seek recovery on behalf of the impacted Self-Funded Health Plans and for payments made by the Fully-Insured Health Plans.

NETWORK OF PARTICIPATING PROVIDERS

77. Enrollees of BCBS Plans are considered the BCBS Plans' "members."

78. The BCBS Plans rely upon networks of participating (also known as "in-network") healthcare providers. Participating providers contract with BCBS Plans to accept a negotiated rate for their services, in exchange for, among other things, increased access to members of BCBS Plans (due to the savings available

to the BCBS Plans' members who receive treatment from participating providers) and increased certainty as to the amount they will be paid by the BCBS Plans.

79. Non-participating (or "out-of-network") providers have not contracted with the BCBS Plans. The reimbursement rates that BCBS Plans are required to pay non-participating providers are often less than BCBS Plans are contractually obligated to pay participating providers, and BCBS Plans' members are typically personally responsible for a larger share of the cost of those services.

80. Chestatee is one of BCBS Georgia's participating providers.

81. None of the other Defendants are participating providers.

THE BCBS GEORGIA-CHESTATEE CONTRACTS

82. The claims at issue were submitted to BCBS Georgia under the three contracts that govern BCBS Georgia's relationship with Chestatee.

83. In January 1987, BCBS Georgia entered into a Participating Hospital Agreement with St. Joseph Hospital of Dahlonega, Inc., d/b/a Chestatee Regional Hospital (the "PAR Contract"). A true and correct copy of the PAR Contract, as subsequently amended, is attached as Exhibit A hereto.

84. In May 1998, HMO Georgia, Inc., a subsidiary of BCBS Georgia, entered into a Contract with Chestatee Regional Hospital (the "HMO Contract"). A true and correct copy of the HMO Contract, as amended, is attached as

Exhibit B hereto.

85. In May 1998, BCBS Georgia entered into a Hospital Agreement for Preferred Provider Program with Chestatee Regional Hospital (the "PPO Contract").[3] A true and correct copy of the PPO Contract, as amended, is attached as Exhibit C hereto.

86. On August 19, 2016, the day that Durall Capital acquired Chestatee Regional Hospital, Southern Health Corporation of Dahlonega assigned the three contracts (PAR Contract, HMO Contract, and PPO Contract) to Durall Capital.

87. Unaware of Chestatee's fraudulent intentions, BCBS Georgia consented to the assignments.

88. Through the assignments, Durall Capital agreed "to be bound by all terms and conditions of" the Contracts, and BCBS Georgia and Durall Capital agreed that "all other terms and conditions of [the Contracts] remain[ed] in full force and effect." (*See* Exs. A-C.)

[3] On December 14, 2018, the Court ordered Plaintiffs to arbitrate its claims arising under the PPO Contract against Chestatee, Reliance Labs, Medivance, Aaron Durall, and Neisha Carter Zaffuto. (*See* Dkt. 122.) However, Plaintiffs claims against Jorge Perez arising under the PPO Contract remain in this action. (*Id.*)

THE PAR CONTRACT

89. The PAR Contract makes clear that BCBS Georgia would reimburse Chestatee only for hospital services provided by Chestatee to BCBS members.

90. The PAR Contract states that Chestatee "shall provide Medically Necessary Hospital Services to Subscribers as provided in the applicable Benefit Agreement when ordered by a licensed physician or other licensed medical professionals and are within the bylaws of the hospital." (Ex. A at ¶ 4.1.)

91. The first provision relating to BCBS Georgia's responsibilities under the PAR Contract states that BCBS Georgia must compensate Chestatee for "Covered Services *rendered* to Subscribers pursuant to the provisions of [the PAR Contract]." (Ex. A at ¶ 5.1. (emphasis added).)

92. Other relevant provisions of the PAR Contract include:

a. Chestatee and BCBS Georgia agreed that the latter would "pay [Chestatee] directly for Covered Services rendered to Subscribers" pursuant to the PAR Contract. (Ex. A at ¶ 5.1.)

b. Chestatee agreed to allow BCBS Georgia to conduct bill and utilization audits, and to conduct "such other activities as are deemed mutually necessary to ensure correct payment to [Chestatee] for Covered Services rendered to a Subscriber." (Ex. A at ¶ 4.7.)

c. The PAR Contract described payment for services not rendered at Chestatee Regional as being "made in error." (Ex. A at ¶ 6.4.)

d. Chestatee was obligated to maintain "all appropriate records on Subscribers" receiving services at Chestatee. (Ex. A at ¶ 8.1.)

e. Chestatee agreed that BCBS Georgia would be "permitted to recover from [Chestatee] amounts due to [BCBS Georgia] because of," among other things, "inaccurate payments, including payments based upon erroneous or incomplete information provided by [Chestatee.]" (Ex. A at ¶ 6.4.)

f. Chestatee agreed not to assign its "rights, duties or obligations of the [Contract]," and not to subcontract the PAR Contract, or any portion thereof, without written consent from BCBS Georgia. (Ex. A at ¶¶ 13.1–13.2.)

THE HMO CONTRACT

93. The HMO Contract establishes the obligations of BCBS Georgia and Chestatee for the provision of health care services at Chestatee to enrollees of BCBS Georgia and its affiliates' health maintenance organization ("HMO") plans.

94. The HMO Contract makes clear that BCBS Georgia contracted to reimburse Chestatee only for services provided by Chestatee.

95. The first substantive provision of the HMO Contract, which details Chestatee's responsibilities under the Contract, states that Chestatee "shall provide to Members and Guest Members" in the hospital's service area "Covered Services in accordance with this Agreement, when such services are ordered by a Physician or other licensed health professional." (Ex. B at ¶ 3.1.)

96. The first provision relating to BCBS Georgia's responsibilities states that BCBS Georgia must compensate Chestatee for "Covered Services rendered by [Chestatee] to Members[.]" (Ex. B at ¶ 5.2.)

97. Other relevant provisions of the HMO contract include:

a. Chestatee agreed to "accept [BCBS Georgia's payments], as payment in full for Covered Services." (Ex. B at ¶ 5.2.)

b. Chestatee agreed that its "charges for Covered Services rendered to Members" would not exceed its regular billed charges made to non-members for the same services. (Ex. B at ¶ 5.3.)

c. Chestatee agreed to provide, upon request, "all information reasonably required [by BCBS Georgia], . . . including, but not limited to, complete and accurate descriptions of health care services performed and charges made, with diagnoses and procedure codes approved [by BCBS Georgia]." (Ex. B at ¶ 5.5.)

d. Chestatee agreed to use its best efforts to submit all bills for "Covered Services provided *to* Members within thirty (30) days after the services [were] rendered[.]" (Ex. B at ¶ 5.10.)

e. Chestatee was obligated to maintain records on HMO members "receiving Covered Services at [Chestatee]." (Ex. B at ¶ 8.1.)

g. Chestatee agreed that BCBS Georgia would be "permitted to recover from [Chestatee] . . . amounts paid by [BCBS Georgia] because of," among other things, "inaccurate payments, including, but not limited to, payments based upon erroneous or incomplete information provided by [Chestatee.]" (Ex. B at ¶ 5.6.)

h. Chestatee agreed not to assign its "rights, duties or obligations of the [Contract]." (Ex. B at ¶ 14.2.)

i. Chestatee agreed to "indemnify and hold [BCBS Georgia] harmless from any and all liability, loss, damage, claim or expense of any kind, including costs and attorney's fees, … which results from negligent or willful acts or omissions by [Chestatee], its agents or employees regarding the duties and obligations of [Chestatee] under [the HMO Contract.]" (Ex. B at ¶ 9.2.)

j. Chestatee was required to maintain comprehensive general liability insurance, and such other insurance as would be necessary to insure Chestatee and its employees "against any and all claims for damages arising from the duties and obligations of [the HMO Contract.]" (Ex. B at ¶ 9.5.)

THE PPO CONTRACT

98. The PPO Contract also makes clear that BCBS Georgia contracted to reimburse Chestatee only for services provided by Chestatee.

99. Indeed, the first substantive provision of the PPO Contract, which details Chestatee's responsibilities under the Contract, states that Chestatee "shall provide to PPO Covered Persons PPO Eligible Services which are Medically Necessary in accordance with [the PPO Contract], when such services are ordered by a licensed physician or other licensed health professional." (Ex. C at ¶ 2.1.)

100. Similarly, the first provision of the PPO Contract addressing BCBS Georgia's responsibilities states that BCBS Georgia must compensate Chestatee for eligible services "which [Chestatee] performs for PPO Covered Persons pursuant to the provisions of [the PPO Contract]." (Ex. C at ¶ 3.1.)

101. Other relevant provisions of the PPO Contract include:

a. Chestatee agreed to "accept [BCBS Georgia's] payments, as provided in [the Contract], as payment in full for Eligible Services provided to PPO Covered Persons." (Ex. D at ¶ 2.3.)

b. Chestatee agreed to allow BCBS Georgia to conduct hospital bill and utilization audits, and to "permit such other activities as are deemed necessary by [BCBS Georgia] to ensure correct payment to [Chestatee] for PPO Eligible Services rendered to PPO Covered Persons." (Ex. C at ¶ 2.11.)

c. Chestatee agreed that BCBS Georgia would "pay [Chestatee] for the provision of medically necessary and appropriate PPO Eligible Services rendered to PPO Covered Persons in accordance with the provisions of [the PPO Contract.]" (Ex. C at ¶ 4.1.)

d. Chestatee agreed to use its best efforts to submit all bills for "Eligible Services provided *to* PPO Covered Persons within sixty (60) days after the services [were] rendered[.]" (Ex. C at ¶ 4.11.)

e. BCBS Georgia explicitly reserved the right to "review any PPO claim for Medical Necessity, Appropriateness, and/or to determine that services provided are Eligible Services under the terms of the PPO

Covered Person's Membership Agreement prior to payment." (Ex. C at ¶ 5.7.)

f. Chestatee agreed that BCBS Georgia would be "permitted to recover from [Chestatee] amounts due to [BCBS Georgia] because of," among other things, "inaccurate payments including payments based upon erroneous or incomplete information provided by [Chestatee.]" (Ex. C at ¶ 4.6.)

g. BCBS Georgia's obligation to pay for claims was contingent upon Chestatee's bills being "accurate, complete, properly itemized and clearly for medically necessary and appropriate PPO Eligible Services." (Ex. C at ¶ 3.2.)

h. Chestatee agreed not to assign its "rights, duties or obligations of the [PPO Contract]," and that it would not subcontract the PPO Contract, or any portion thereof, without written consent from BCBS Georgia. (Ex. C at ¶¶ 13.1-13.2.)

i. Chestatee agreed to "indemnify and hold [BCBS Georgia] harmless from any and all liability, loss, damage, claim or expense of any kind, including costs and attorney's fees, … which results from negligent or willful acts or omissions by [Chestatee], its agents or employees

regarding the duties and obligations of [Chestatee] under [the PPO Contract.]" (Ex. C at ¶ 8.2.)

SUMMARY OF DAMAGES

102. Since August 2016, Chestatee has billed BCBS Georgia more than $163 million for the laboratory tests at issue, causing the BCBS Plans to reimburse Chestatee approximately $103 million.

103. Under the HMO Contract, Chestatee inappropriately billed BCBS Georgia approximately $3.65 million, causing the BCBS Plans to reimburse Chestatee approximately $2.28 million. Through this lawsuit, the BCBS Plans seek recovery of this entire amount from all Defendants.

104. Under the PAR Contract, Chestatee inappropriately billed BCBS Georgia approximately $6.45 million, causing the BCBS Plans to reimburse Chestatee approximately $4.79 million. Through this lawsuit, the BCBS Plans seek recovery of this entire amount from all Defendants.

105. Under the PPO Contract, Chestatee inappropriately billed BCBS Georgia approximately $153 million, causing the BCBS Plans to reimburse

Chestatee approximately $96.5 million. Through this lawsuit, the BCBS Plans seek recovery of this entire amount from Jorge Perez.[4]

FACTUAL BACKGROUND

URINE DRUG TESTING

106. Drug tests are laboratory analyses used to aid in the detection of prescription, recreational, or illicit substances in human specimens.

107. Although drug tests may be performed on a variety of specimen types, urine-drug testing is the most commonly used because it is widely available, minimally invasive, and generally the least expensive for drug detection and monitoring.

108. This is consistent with Anthem's Clinical UM Guideline, entitled "Drug Testing or Screening in the Context of Substance Use Disorder and Chronic Pain" (the "Anthem Drug Testing Policy") which states that "the use of blood samples as an alternative to urine for drug testing is considered medically necessary when the use of urine is not feasible[.]"

109. Urine-drug testing falls into two categories of testing: presumptive and definitive.

[4] The BCBS Plans' claims against Chestatee, Reliance Labs, Medivance, Aaron Durall, and Neisha Carter Zaffuto will be arbitrated in accordance with the Court's Order dated December 14, 2018. (*See* Dkt. 122.)

110. Presumptive testing is used, when medically necessary, to determine the presence or absence of one or more drugs or drug classes. Presumptive testing is typically performed via immunoassay, and results are expressed as negative, positive, or numeric. It is also referred to as "screening" or "qualitative" testing.

111. Definitive testing is a follow-up test performed on a separate portion of the original specimen, when medically necessary, to validate the identity and quantity of a specific drug or metabolite. Definitive testing is typically performed using either gas chromatography-mass spectrometry or liquid chromatography-mass spectrometry, and results are expressed as a concentration of a particular metabolite or analyte (*e.g.*, nanograms per milliliter (ng/mL)). It is also referred to as "confirmation" or "quantitative" testing.

112. Definitive testing is typically reasonable and necessary only in certain circumstances.

113. The Anthem Drug Testing Policy states that definitive testing is medically necessary only when all of the following criteria are met:

a. presumptive urine-drug testing was done for a medically necessary reason; and

b. presumptive test was negative for prescribed medications, positive for a prescription drug with abuse potential which was not prescribed, or positive for an illegal drug (for example, but not limited to, methamphetamine or cocaine), and

i. the specific definitive test(s) ordered are supported by documentation specifying the rationale for each [definitive] test ordered, and

ii. clinical documentation reflects how the result of the test(s) will be used to guide clinical care.

THE TOXICOLOGY LABORATORY INDUSTRY

114. In recent years, government enforcement, private lawsuits, and investigative journalism have helped identify widespread fraud within the toxicology laboratory industry.

115. For example, in a November 2014 article about the massive increases in the amount of urine-drug testing being paid for by Medicare, the Wall Street Journal summarized the then-recent history of the industry:

> Spending on the [urine drug] tests took off after Medicare cracked down on what appeared to be abusive billing for simple urine tests. Some doctors moved on to high-tech testing methods, for which billing wasn't limited.

> They started testing for a host of different drugs—including illegal ones that few seniors ever use—and billing the federal health program for the elderly and disabled separately for each substance.
>
> Medicare's spending on 22 high-tech tests for drugs of abuse hit $445 million in 2012, up 1,423% in five years.[5]

116. Because of concerns about the frequency, cost, and manner with which toxicology laboratories were billing payors, a number of changes were put into place as to how laboratories test and bill for urine-drug testing.

117. For example, the Centers for Medicare and Medicaid Services ("CMS") changed the way that urine-drug testing is billed, in part because of a "concern about the potential for overpayment when billing for each individual drug test rather than a single code that pays the same amount regardless of the number of drugs that are being tested."

118. Because these changes have decreased the rate at which toxicology laboratories are reimbursed for urine-drug testing, some laboratories have sought out ways to access more favorable reimbursement rates, including—as

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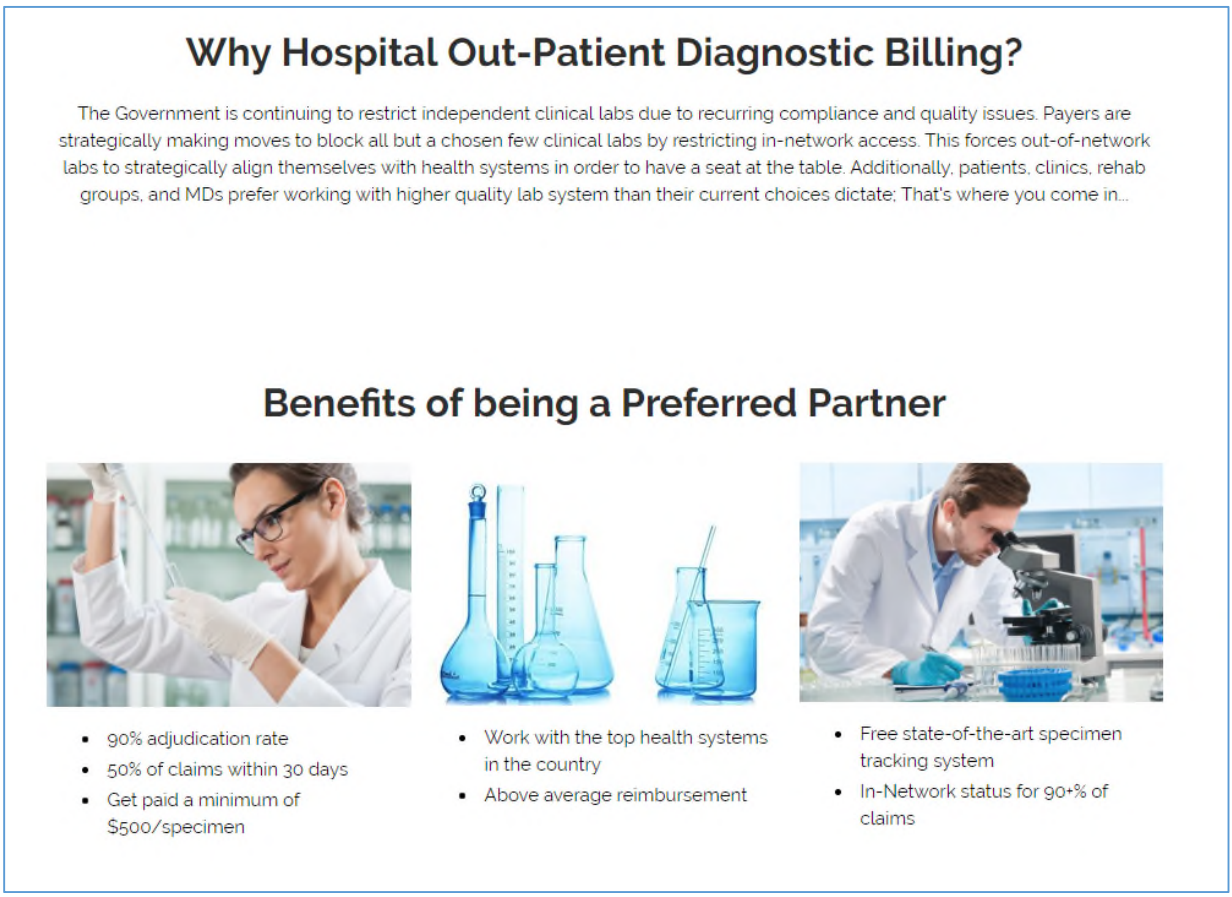
[5] Christopher Weaver and Anna Wilde Mathews, *Doctors Cash In on Drug Tests for Seniors, and Medicare Pays the Bill*, THE WALL STREET JOURNAL, Nov. 10, 2014 (available at: https://www.wsj.com/articles/doctors-cash-in-on-drug-tests-for-seniors-and-medicare-pays-the-bill-1415676782).

here—passing their claims through hospitals to take advantage of the hospitals' participating status and favorable reimbursement rates with payors.

119. The website of one entity that recruited toxicology laboratories to pass their claims through a different network of pass-through hospitals makes clear the motives of the arrangement:



Why Hospital Out-Patient Diagnostic Billing?

The Government is continuing to restrict independent clinical labs due to recurring compliance and quality issues. Payers are strategically making moves to block all but a chosen few clinical labs by restricting in-network access. This forces out-of-network labs to strategically align themselves with health systems in order to have a seat at the table. Additionally, patients, clinics, rehab groups, and MDs prefer working with higher quality lab system than their current choices dictate; That's where you come in...

Benefits of being a Preferred Partner

- 90% adjudication rate
- 50% of claims within 30 days
- Get paid a minimum of $500/specimen

- Work with the top health systems in the country
- Above average reimbursement

- Free state-of-the-art specimen tracking system
- In-Network status for 90+% of claims

120. In other words, because of "recurring compliance and quality issues," CMS and commercial payors restricted certain laboratories from their networks. This led some of the remaining laboratories—including those who

were restricted from payors' networks for compliance and quality issues—to use hospitals like Chestatee to hide the true identity of the laboratory performing the urine-drug testing.

THE DEFENDANTS' PASS-THROUGH BILLING SCHEME

121. Durall Capital purchased Chestatee in August 2016.

122. Around the same time, Aaron Durall (individually or through Durall Capital) engaged Jorge Perez to manage Chestatee's finances and help oversee the scheme.

123. Jorge Perez owns or manages, indirectly, a number of other small hospitals, through which he has engaged in similar schemes.

124. Jorge Perez and Aaron Durall previously conspired to implement at least one other known pass-through billing scheme, at Campbellton-Graceville Hospital in Graceville, Florida. There, Perez served as Campbellton-Graceville's Chief Executive Officer after it was acquired by The People's Choice Hospital, LLC.[6] At the direction of Aaron Durall, Reliance Labs performed laboratory tests at Reliance Labs that were billed to insurers as if performed at

[6] People's Choice is itself the defendant in separate actions arising from yet more fraudulent billing schemes. One arose due to its relationship with the Campbellton-Graceville Hospital. *See Campbellton-Graceville Hosp. Corp. v. Peoples Choice Hosp.*, No. 5:16-cv-00222 (N.D. Fla. filed Aug. 3, 2016). Another was perpetrated in Oklahoma. *See Aetna Inc. v. The People's Choice Hosp., LLC*, No. 2:17-cv-04354 (E.D. Pa. filed Sept. 29, 2017) (recently transferred to the Western District of Texas).

and by Campbellton-Graceville Hospital. Through the scheme, Reliance Labs received approximately $25 million.

125. Jorge Perez is also vice president of Hospital Partners, Inc., which implemented a scheme in Missouri similar to the one alleged herein. That arrangement was the subject of an audit by the State Auditor of Missouri, who described it as a "billing scheme" whereby the hospital was "reduc[ed] to what is essentially a shell organization for labs across the country."[7]

126. Once Durall Capital acquired Chestatee Regional Hospital, it began billing BCBS Georgia for high volumes of urine-drug testing.

127. Aaron Durall used his control of Chestatee and Reliance Labs to bill the claims through Chestatee, camouflaging the claims so that the BCBS Plans would be more likely to pay them, and would pay them at the higher rates that Chestatee was entitled to under its contracts with BCBS Georgia if the tests were ordered from and performed by Chestatee.

128. Reliance Labs engaged marketing firms to drum up test orders.

129. Providers ordered tests from Reliance Labs.

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[7] The State Auditor's report, which is incorporated herein, is accessible via the following link: https://www.auditor.mo.gov/content/auditor-galloway-uncovers-evidence-90-million-billing-scheme-putnam-county-memorial-hospital (last visited Feb. 22, 2018). The State Auditor's press release announcing its findings is available via the following link: https://auditor.mo.gov/content/auditor-galloway-uncovers-evidence-90-million-billing-scheme-putnam-county-memorial-hospital (last visited Feb. 22, 2018).

130. Providers shipped their patients' specimens to Reliance Labs' facility in Florida via Federal Express.

131. Reliance Labs conducted definitive testing of the patient's specimens.

132. Reliance Labs reported the test results to the ordering providers through a portal on Reliance Labs' website.

133. Reliance Labs then shipped some of the patients' specimens to Chestatee and other hospitals controlled by the Defendants.

134. Chestatee then performed presumptive testing on some portion of the patient specimens. However, these tests were never ordered from Chestatee and provided no clinical utility beyond the definitive tests already performed by Reliance and reported to the ordering providers. Upon information and belief, the tests conducted at Chestatee were designed to make it appear as though Chestatee was more involved in the testing than it actually was.

135. Medivance billed the tests to the BCBS Plans on behalf of Chestatee.

136. Neisha Carter Zaffuto managed Medivance's efforts in accordance with Defendants' collective agreement.

137. Aaron Durall directed the scheme in his capacity as CEO of Chestatee Regional Hospital, President of Reliance Labs, and Manager of DL Investment Holdings, LLC.

138. In exchange for their respective acts in furtherance of the pass-through scheme, the Defendants split the proceeds.

139. To increase the revenues that they could generate from the pass-through scheme, Defendants relied upon a network of referring healthcare providers who ordered large volumes of laboratory testing (including, most notably, pain clinics and drug detoxification and rehabilitation facilities).

140. To ensure that they received the specimens referred by these providers, Reliance Labs paid some providers kickbacks (*e.g.*, by paying the providers a portion of the reimbursement that Chestatee received for the tests).

141. Upon information and belief, Aaron Durall instructed personnel at Chestatee's on-site laboratory to destroy the lab results created by the laboratory equipment there, apparently to avoid creating documentary proof of which tests were conducted on-site (as opposed to at Reliance Labs).

142. Upon information and belief, one reason for this instruction was that the equipment at Chestatee Regional Hospital's on-site laboratory was only

capable of testing in panels of eight or fewer drugs or metabolites. However, Chestatee billed BCBS Georgia for panels of up to 24 drugs or metabolites.

143. The claims were billed to BCBS Georgia by Medivance, on behalf of Chestatee, as if the tests were ordered from and performed by Chestatee.

144. Chestatee, Medivance, Reliance Labs, Aaron Durall, Jorge Perez, and Neisha Carter Zaffuto agreed to submit the claims in this manner, and each took the overt acts described herein to facilitate the billing of the claims.

145. The claims submitted to BCBS Georgia contained numerous material misrepresentations intended to hide the fact that the tests were ordered from and performed by Reliance Labs (and not by Chestatee), including:

a. submission of the claims on a Form UB-04 (indicating that tests were conducted at a facility like a hospital, rather than at a standalone laboratory);

b. provider name (misrepresented as Chestatee);

c. provider street address (misrepresented as Chestatee);

d. provider Tax ID and National Provider Identifier ("NPI") (misrepresented as Chestatee);

e. type of bill (misrepresented as 141, which represents a specimen submitted for analysis to a hospital);

f. admission type (misrepresented as "urgent" admission when no patient was ever admitted at Chestatee Regional Hospital);

g. source of admission (misrepresented as "information not available," when there was no admission);

h. patient discharge status (misrepresented as a patient discharged to home or self-care, when there was no admission or discharge); and

i. attending physician and attending physician's NPI (misrepresented as the provider ordering the tests).

146. When they submitted claims to BCBS Georgia, Chestatee, Medivance, Reliance Labs, Aaron Durall, Jorge Perez, and Neisha Carter Zaffuto falsely certified on each claim that the billing information was "true, accurate, and complete[.]" On each claim, the Defendants falsely certified that they "did not knowingly or recklessly disregard or misrepresent or conceal material facts."

147. The claim form contains a notice that the submitter of the form "understands that misrepresentation or falsification of essential information as requested by this form, may serve as the basis for civil monetary penalties and assessments and may upon conviction include fines and/or imprisonment under federal and/or state laws."

148. BCBS Georgia reasonably relied on the material misrepresentations contained on Chestatee's claims in deciding to pay the claims.

149. Chestatee, Medivance, Reliance Labs, Aaron Durall, Jorge Perez, and Neisha Carter Zaffuto sought to hide from BCBS Georgia the identity of the laboratory where the tests were ordered from and conducted.

150. Indeed, had Defendants disclosed the identity of the laboratory performing the testing (*i.e.*, Reliance Labs), the BCBS Plans would not have paid the claims at issue or would have paid them at substantially lower rates.

151. When Reliance Labs billed BCBS Georgia directly, BCBS Georgia typically paid between $100 and $300 per specimen tested. On the other hand, when the testing was billed through Chestatee, the Defendants caused BCBS Georgia to pay more than $1,400 per specimen tested.

152. Once Chestatee received payment from BCBS Georgia, Chestatee shared the proceeds with the other Defendants.

153. Upon information and belief, the Defendants had no written contracts setting forth the amounts that they were each entitled to, and instead allocated the proceeds on an *ad hoc* basis.

154. From the payments made by BCBS Georgia, employees or agents of Reliance Labs paid kickbacks to healthcare providers who referred their patients' specimens to be used in the scheme.

155. Upon information and belief, Durall Capital and Aaron Durall purchased Chestatee Regional specifically to perpetrate this pass-through scheme.

DEFENDANTS' EFFORTS TO PREVENT THE SCHEME FROM BEING UNCOVERED

156. The Defendants relied on a small group of key staff to execute the scheme and kept many other employees isolated so that they would not come to understand the fraudulent scheme.

157. For example, mail sent to Chestatee was forwarded unopened to Aaron Durall or Neisha Carter Zaffuto, who facilitated the scheme from Florida. Once the mail was reviewed in Florida, select communications that would not reveal the existence of the scheme were returned to Chestatee Regional Hospital's facility in Georgia.

158. When Neisha Carter Zaffuto learned that patients were calling Chestatee Regional Hospital to ask why they were receiving bills or explanation of benefits from the hospital when they had never been treated there, she

arranged to have the calls routed away from staff on-site at the hospital to another phone line that she had control of.

159. Reliance Labs' employees were also kept in the dark about the work their colleagues did.

160. In February 2017, after identifying the spike in claims for urine-drug testing from Chestatee, an Anthem investigator sent a letter to Chestatee requesting records (including requisition forms, test results, medical records, and supporting documentation) for 15 members of the BCBS Plans who had urine-drug testing billed through Chestatee.

161. In March 2017, in response to a complaint from a member who received an explanation of benefits from Chestatee even though she was never treated there, a customer service representative from a BCBS Plan spoke with Kelly Smallwood, a Business Manager at Chestatee. Smallwood said that, since the sale of Chestatee in August 2016, claims were being billed for "patients" who had never been to Chestatee.

162. Later in March 2017, Chestatee responded to the records request but provided only a fraction of the records requested of it.

163. When an Anthem investigator contacted Chestatee's on-site laboratory to ask follow-up questions about the production, the on-site laboratory director said she was unaware of BCBS Georgia's records request.

164. The Anthem investigator agreed to fax the records he received to Chestatee's on-site laboratory director.

165. Around the same time, the BCBS Georgia investigator received multiple calls from Neisha Carter Zaffuto (from a number with a Florida area code), requesting that he direct his questions to her, rather than to the hospital's on-site laboratory director.

166. After reviewing the records from the BCBS Georgia investigator, Chestatee Regional Hospital's on-site laboratory director spoke with Jaquanda Smith, Chestatee's "Director of Operations/HIM."

167. Among other things, the on-site laboratory director informed Jaquanda Smith that the test results identified by BCBS Georgia were for panels of up to 24 drugs or metabolites, which the on-site laboratory director knew could not have been performed at Chestatee Regional's on-site laboratory.

168. Jaquanda Smith told the on-site laboratory director that she would respond to BCBS Georgia, and that the on-site laboratory director should not discuss the matter with anyone else.

169. Jaquanda Smith then wrote to the BCBS Georgia investigator: "Chestatee Regional Hospital completed and generated reports for all the tests you inquired about."

170. In response to further questioning from the BCBS Georgia investigator, Jaquanda Smith added: "I am affirming that the testing results were completed at chestatee [*sic*]."

171. At the time that Jaquanda Smith made these statements, in her capacity as an employee of Chestatee, she knew that they were false, and made them with the intent to further the fraudulent scheme described herein.

172. One employee of Chestatee Regional Hospital also stated that, because Chestatee was concerned that payors would conduct inspections of Chestatee Regional Hospital's on-site laboratory, Chestatee was rushing to install a machine capable of testing panels of up to 24 drugs or metabolites.

173. On April 12, 2017, the BCBS Georgia investigator sent a letter to Aaron Durall summarizing BCBS Georgia's analysis of the sample claims and the records provided by Chestatee in support of the sample claims.

174. The findings summarized included the following:

a. much of the urine-drug testing billed by Chestatee was not medically necessary;

b. many tests were performed based upon standing orders that were either signed or stamped blank prescriptions;

c. definitive tests were frequently billed as presumptive tests;

d. the majority of the BCBS Plans' members were tested at excessive frequencies (often more than 24 times per calendar year);

e. the frequency of testing was often too frequent (i.e., near daily) to allow for meaningful use of the tests in medical decision-making, as additional tests were often ordered before the healthcare providers received the results of the previous tests;

f. many BCBS Plan members had urine-drug testing billed by both Reliance Labs and Chestatee and, when taking the collective volume into account, the frequency with which the members were tested was even more excessive;

g. in some cases, the "client" field on the test results identified other laboratories for urine-drug testing purportedly performed by Chestatee;

h. Chestatee employees reported that they were not permitted to talk to the Anthem investigator or cooperate with his requests; and

i. the medical records provided by Chestatee in response to the records request were prepared and submitted by persons in Florida, and did not appear to be from Chestatee Regional Hospital.

175. Even after being notified of the serious misrepresentations being made in the claims submitted to BCBS Georgia, Defendants continued to execute their scheme.

176. In April 2017, in response to the letter from the Anthem investigator, an attorney for Chestatee wrote that, "[b]ased upon our internal investigation subsequent to your February audit of records, we identified an area of non-compliance and, in conjunction with [a statistician], will be submitting a voluntary refund and disclosure within the next 45-60 days."

177. For three months, the Anthem investigator worked with Chestatee's attorney, who repeatedly assured the Anthem investigator that Chestatee was conducting a thorough internal investigation.

178. In May 2017, the BCBS Plans attempted to place Chestatee on pre-payment review, a process through which Chestatee would be required to provide records documenting the propriety of each claim before the claims were paid. However, the fact that the claims were being billed from a hospital caused

technical issues and prevented pre-payment review from attaching to Chestatee's claims for some time.

179. In approximately September 2017, the pre-payment review became effective.

180. In an effort to get around scrutiny of their claims (including the pre-payment review), the Defendants required ordering providers to sign a standard "Letter of Medical Necessity." The forms were required to be sent to Reliance Labs along with the test order forms and patient specimens.

181. However, the template for the Letter of Medical Necessity contained a Reliance Labs logo. As a result, Reliance Labs had a team of employees who were responsible for redacting the Reliance Labs logo on the Letters of Medical Necessity before the claims were submitted to payors, including the BCBS Plans.

182. Between May 2017 and October 2017, BCBS Georgia's team responsible for provider contracting tried to engage Chestatee, but Chestatee refused to modify the operative contracts until BCBS Georgia began taking steps to terminate Chestatee from the BCBS Plans' provider networks.

183. In September 2017, with the termination of its contracts with BCBS Georgia imminent, Chestatee agreed to amend its contracts with BCBS Georgia.

184. Shortly thereafter, the PPO, PAR, and HMO Contracts were amended to include Lab Fee Schedules that set the amounts that Chestatee would receive for laboratory tests, including urine-drug testing. True and correct copies of the Lab Fee Schedules are included in Exhibits A-C.

185. The Lab Fee Schedules listed laboratory codes and the rates that BCBS Georgia would pay Chestatee for each service.

186. For any laboratory codes not listed on the Lab Fee Schedule, the parties agreed that they would "price at $0.00."

187. In response, Defendants made at least three changes to the way that they billed the BCBS Plans for urine-drug testing, apparently in order to conceal that the claims were subject to the Lab Fee Schedules.

188. First, prior to the implementation of the Lab Fee Schedule, Defendants would submit claims using CPT and HCPCS[8] codes that identified the bills as laboratory-related. After the implementation of the Lab Fee Schedule, Defendants began submitting claims without these CPT or HCPCS codes, and using only revenue codes, in an effort to hide that they were laboratory-related.

[8] "CPT" stands for "Current Procedural Terminology," and is a medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations. "HCPCS" stands for "Healthcare Common Procedure Coding System" and is a code set used by Medicare and health insurance providers to standardize billing.

189. Second, the Defendants began billing the claims with bill type 131, rather than bill type 141 as they had been using since taking over Chestatee. Bill type 131 indicates that a bill is for a hospital outpatient, which does not properly describe the status of the BCBS Plans' members whose tests were billed through Chestatee.

190. Third, the Defendants changed the diagnosis codes that they billed to the BCBS Plans to hide the fact that they were laboratory-related. Whereas the Defendants previously billed claims using diagnosis codes like F11.20 (for opioid dependence), they changed and began using diagnosis code Z00.00 (for a general adult medical examination without abnormal findings).

191. The Defendants took the steps outlined above in order to ensure that their fraudulent scheme continued for as long as possible.

VEIL-PIERCING NOTICE

192. In addition to their direct liability, the individual Defendants are personally liable for the entity Defendants' wrongdoing because, among other things: (a) the Defendants have disregarded their respective corporate entities; (b) the entity Defendants are being used to evade statutory, contractual, and tort responsibility; (c) the entity Defendants are being used to hinder, delay, and defraud creditors; (d) a fraud would result of the entity Defendants were allowed

to shield their shareholders and members from liability; (e) the entity Defendants are a sham and are being used to justify a wrong; (f) the individual Defendants withdrew funds from insolvent entity Defendants, thereby constituting fraudulent transfers of assets from the entity Defendants; (g) the Defendants failed to follow corporate formalities; and (h) the Defendants commingled funds.

SAMPLE CLAIMS

193. As described above, BCBS Georgia requested that Chestatee provide medical records, "including all testing results, requisition forms, provider medical records and all supporting documentation" for a sample of the claims at issue.

194. From that documentation, the BCBS Plans have identified the following claims as illustrative of Defendants' scheme.

SAMPLE CLAIM SET #1

195. On October 5, 2016, a doctor of osteopathic medicine affiliated with a detoxification and rehabilitation facility in Costa Mesa, California completed a "Standing Order" form for a BCBS Georgia member. That BCBS Plan member is referred to herein as Member #1.

196. BCBS Georgia was billed four times by Chestatee for urine-drug testing collected from Member #1 even before the Standing Order was signed.

Chestatee failed to provide an order form for any of these four tests.

197. The Standing Order identifies Member #1's name, date of birth, and the date the Standing Order was completed. A section of the form where the treating provider was to list Member #1's prescriptions is blank. In the section entitled "Dx," where the treating provider was to provide a diagnosis, a notation states "3x a week." Upon information and belief, this indicates that Member #1 was to be subjected to urine-drug testing three times per week. Finally, the Standing Order was stamped with the treating provider's signature, rather than being signed.

198. The first urine-drug testing results provided by Chestatee are for a specimen collected from Member #1 on October 5, 2016.

199. Those results have Chestatee's logo, name, and address across the top of their first page. The field for Chestatee's phone number is blank.

200. On the test results, the laboratory director identified as responsible for the tests is "Mills Brinson III, CLD." When contacted by BCBS Georgia, Brinson denied ever being affiliated with Chestatee or Reliance Labs. Brinson stated that he was once the lab Director for Regional General Hospital in Williston, Florida. Regional General Hospital is affiliated with EmpowerHMS, an entity operated by Jorge Perez.

201. The test result form also includes a space for Member #1 to "consent and agree" to provide his urine specimen "to the facility designated by [his] doctor as described above." However, none of the test result forms provided by Chestatee were signed by Member #1. Further, the form containing this waiver appears to have been created three days after the urine was collected from Member #1, and purports to have been created at Chestatee, thousands of miles away from the rehabilitation facility at which Member #1 was receiving treatment.

202. Member #1's urine specimen was purportedly subjected to presumptive testing for 24 drug classes, all of which tested not present.

203. Upon information and belief, these tests were performed at Reliance Labs.

204. Yet, Chestatee billed BCBS Georgia, or caused BCBS Georgia to be billed, for the testing on a claim that misrepresented, among other things:

a. submission of the claims on a Form UB-04 (indicating that tests were conducted at a facility like a hospital, rather than at a standalone laboratory);

b. provider (misrepresented as Chestatee);

c. provider's street address (misrepresented as Chestatee);

d. provider's Tax ID and NPI (misrepresented as Chestatee);

e. type of bill (misrepresented as "141," which represents a specimen submitted for analysis to a hospital);

f. admission type (misrepresented as "2," which stands for "urgent" admission, when there was no admission);

g. source of admission (misrepresented as "9," which stands for "information not available," when there was no admission);

h. patient discharge status (misrepresented as "01," which represents a patient discharged to home or self-care, when there was no admission or discharge); and

i. attending physician and attending physician's NPI (misrepresented the referring provider as an attending physician).

205. The testing was billed to BCBS Georgia using one count of HCPCS code G0479, for which Chestatee charged $2,700.

206. BCBS Georgia allowed $1,792.31 based on the reimbursement guidelines set forth in the PPO Contract. Member #1 owed no copay or coinsurance, so BCBS Georgia paid Chestatee $1,792.31 for the test.

207. Member #1 was not a Chestatee patient, was not treated by a Chestatee-credentialed healthcare provider, and resided thousands of miles from

Chestatee Regional Hospital.

208. But for Defendants' scheme, Chestatee would not have submitted a claim for this testing to BCBS Georgia and BCBS Georgia would not have paid anything to Chestatee for the service.

209. Between September 2016 and August 2017, Chestatee billed BCBS Georgia for 88 urine drug tests for Member #1 that were substantially similar to the one described in Paragraphs 205 through 224, above.

210. In reliance on those 88 fraudulent claims, BCBS Georgia paid Chestatee more than $155,000.

SAMPLE CLAIM SET #2

211. On September 22, 2016, a doctor affiliated with a sober living and intensive outpatient treatment program in Houston, Texas digitally signed a medical record for a BCBS Plan member.

212. That BCBS Plan member is referred to herein as Member #2.

213. Aside from providing basic biographical data, the treating provider's notes state only that he "reviewed psychosocial history and recommend patient comply with the company policy of 3 UA's/week."

214. Upon information and belief, "UA" refers to urinalysis, or urine-drug testing.

215. According to the records provided by Chestatee, the treating provider made identical notations in Member #2's medical record on October 21, 2016, November 23, 2016, and December 22, 2016.

216. In his notation on January 10, 2017, the treating provider purportedly changed his notation slightly, to read, "have reviewed treatment plan and recommend client comply with the company policy of 3 UA's/week."

217. The first UDT results provided by Chestatee for Member #2 are for a specimen collected from him on October 2, 2016.

218. The test results have Chestatee's logo, name, and address across the top of their first page. The field for Chestatee's phone number is left blank.

219. As with Sample Claim Set #1, the test results identify Mills Brinson III, CLD as the lab Director responsible for the tests. Yet, Brinson denies ever being affiliated with Chestatee or Reliance Labs.

220. The test result form also includes a space for Member #2 to "consent and agree" to provide his urine specimen "to the facility designated by [his] doctor as described above." However, the forms use an identical digital signature or are unsigned. In addition, the forms containing the waiver appear to have been created days after each specimen was collected from Member #2, and purportedly were created at Chestatee, hundreds of miles from the facility

where Member #2 received treatment.

221. The urine specimen taken from Member #2 was purportedly subjected to presumptive testing.

222. Upon information and belief, these tests were performed at Reliance Labs.

223. Yet, Defendants billed BCBS Georgia, or caused BCBS Georgia to be billed, for the testing on a claim that misrepresented, among other things:

a. submission of the claims on a Form UB-04 (indicating that tests were conducted at a facility like a hospital, rather than at a standalone laboratory);

b. provider (misrepresented as Chestatee);

c. provider street address (misrepresented as Chestatee);

d. provider Tax ID and NPI(misrepresented as Chestatee);

e. type of bill (misrepresented as "141," which represents a specimen submitted for analysis to a hospital);

f. admission type (misrepresented as "2," which stands for "urgent" admission, when there was no admission);

g. source of admission (misrepresented as "9," which stands for "information not available," when there was no admission);

h. patient discharge status (misrepresented as "01," which represents a patient discharged to home or self care, when there was no discharge); and

i. attending physician and attending physician's NPI (misrepresented the treating provider as an attending physician).

224. The testing was billed to BCBS Georgia using one count of HCPCS code G0479, for which Chestatee charged $2,700.

225. In accordance with the PPO Contract, BCBS Georgia allowed $1,792.31. Member #2 owed no copay or coinsurance, so BCBS Georgia paid Chestatee $1,792.31.

226. Member #2 was not a Chestatee patient, was not treated by a Chestatee-credentialed healthcare provider, and resided thousands of miles from Chestatee.

227. But for Defendants' scheme, Chestatee would not have submitted a claim for this testing to BCBS Georgia and BCBS Georgia would not have paid anything to Chestatee for the service.

228. Between October 2016 and February 2017, Chestatee billed BCBS Georgia for 65 urine drug tests for Member #2 that were substantially similar to the one described in Paragraphs 227 through 246, above.

229. In reliance on those 65 fraudulent claims, BCBS Georgia paid Chestatee more than $104,000.

CAUSES OF ACTION

COUNT I
BREACH OF PAR CONTRACT
(Against Chestatee)

230. The BCBS Plans incorporate by reference all preceding paragraphs as if fully set forth herein and further allege as follows:

231. BCBS Georgia has a contractual relationship with Chestatee, as defined by the PAR Contract and all materials referenced or incorporated therein.

232. BCBS Georgia performed its obligations under the PAR Contract, and all conditions precedent have been satisfied.

233. Chestatee materially breached the PAR Contract, including by:

a. Submitting claims to BCBS Georgia, or causing claims to be submitted to BCBS Georgia, for services not performed by Chestatee. (*See*, *e.g.*, Ex. A at ¶¶ 4.1, 4.2, 4.5, 4.7, 5.1 6.1, 6.2, 6.4, 6.6, 6.10, 7.4, 8.1, 13.1, 13.2.)

b. Assigning its rights, duties, and/or obligations under the Contract, in whole or in part, to Reliance Labs, in violation of the Contract. (*See* Ex. A at ¶ 13.1.)

c. Subcontracting its responsibilities to Reliance Labs, in violation of the Contract. (*See* Ex. A at ¶ 13.2.)

d. Submitting claims to BCBS Georgia, or causing claims to be submitted to BCBS Georgia, that Chestatee knew were not accurate, complete, and truthful, including but not limited to claims containing the following misrepresentations:

i. provider name;

ii. provider street address;

iii. provider Tax ID and NPI;

iv. type of bill;

v. admission type;

vi. source of admission;

vii. patient discharge status;

viii. attending physician and NPI; and

ix. identity of the lab director.

(*See*, *e.g.*, Ex. A at ¶ 5.4.)

e. Submitting claims to BCBS Georgia for medically unnecessary UDT. (Ex. A at ¶ 4.1.)

234. As a direct and proximate consequence of Chestatee's material

breaches of the PAR Contract, the BCBS Plans have suffered damages.

235. Therefore, the BCBS Plans seek to recover, at a minimum, the amount paid on the improper claims that Chestatee submitted or caused to be submitted to BCBS Georgia.

COUNT II
BREACH OF HMO CONTRACT
(Against Chestatee)

236. The BCBS Plans incorporate by reference all preceding paragraphs as if fully set forth herein and further allege as follows:

237. BCBS Georgia has a contractual relationship with Chestatee, as defined by the HMO Contract and all materials referenced or incorporated therein.

238. BCBS Georgia performed its obligations under the HMO Contract, and all conditions precedent have been satisfied.

239. Chestatee materially breached the HMO Contract, including by:

a. Submitting claims to BCBS Georgia, or causing claims to be submitted to BCBS Georgia, for services not performed at or by Chestatee. (*See*, *e.g.*, Ex. B at ¶¶ 3.1, 3.3, 3.5, 3.6, 3.10, 3.11, 3.15, 4.1, 5.1, 5.3, 5.4, 5.5, 5.6, 5.11, 6.1, 7.1.)

b. Assigning its rights, duties, and obligations under the HMO

Contract, in whole or in part, to Reliance Labs. (*See* Ex. B at ¶ 14.2)

c. Submitting claims to BCBS Georgia, or causing claims to be submitted to BCBS Georgia, that Chestatee knew were not accurate, complete, and truthful, including but not limited to claims containing the following misrepresentations:

i. provider name;

ii. provider street address;

iii. provider Tax ID and NPI;

iv. type of bill;

v. admission type;

vi. source of admission;

vii. patient discharge status;

viii. attending physician and NPI; and

ix. the identity of the laboratory director

(*See*, *e.g.*, Ex. B at ¶ 5.6.)

d. Submitting claims to BCBS Georgia for medically unnecessary UDT. (Ex. B at ¶ 3.1.)

240. As a direct and proximate consequence of Chestatee's material breaches of the HMO Contract, the BCBS Plans have suffered damages.

241. Therefore, the BCBS Plans seek to recover, at a minimum, the amount paid on the improper claims that Chestatee submitted or caused to be submitted to BCBS Georgia.

COUNT III
BREACH OF THE COVENANT OF GOOD FAITH AND FAIR DEALING FOR THE PAR CONTRACT
(Against Chestatee)

242. The BCBS Plans incorporate by reference all preceding paragraphs as if fully set forth herein and further allege as follows:

243. Every contract implies a covenant of good faith and fair dealing in the contract's performance and enforcement.

244. BCBS Georgia has a contractual relationship with Chestatee, as defined by the PAR Contract and all materials referenced or incorporated therein.

245. Chestatee violated the implied covenant of good faith and fair dealing by performing the acts described herein, including but not limited to, by fraudulently billing BCBS Georgia for laboratory testing performed at and by Reliance Labs as if it had been performed at and by Chestatee.

246. In so doing, Chestatee failed to diligently and in good faith seek to comply with all portions of the terms of the PAR Contract.

247. As a direct and proximate consequence of Chestatee's breach of the

covenant of good faith and fair dealing, the BCBS Plans have suffered damages in an amount to be determined at trial.

COUNT IV
BREACH OF THE COVENANT OF GOOD FAITH AND FAIR DEALING FOR THE HMO CONTRACT
(Against Chestatee)

248. The BCBS Plans incorporate by reference all preceding paragraphs as if fully set forth herein and further allege as follows:

249. Every contract implies a covenant of good faith and fair dealing in the contract's performance and enforcement.

250. BCBS Georgia has a contractual relationship with Chestatee, as defined by the HMO Contract and all materials referenced or incorporated therein.

251. Chestatee violated the implied covenant of good faith and fair dealing by performing the acts described herein, including but not limited to, by fraudulently billing BCBS Georgia for laboratory testing of non-Chestatee patients that were performed at and by Reliance Labs as if it had been performed at and by Chestatee.

252. In so doing, Chestatee failed to diligently and in good faith seek to comply with all portions of the terms of the HMO Contract.

253. As a direct and proximate consequence of Chestatee's breach of the

covenant of good faith and fair dealing, the BCBS Plans have suffered damages in an amount to be determined at trial.

COUNT V
FRAUD AND FRAUDULENT CONCEALMENT
(Claims Paid under HMO & PAR Contracts – All Defendants; Claims Paid under PPO Contract – Jorge Perez Only)

254. The BCBS Plans incorporate by reference all preceding paragraphs as if fully set forth herein and further allege as follows:

255. As alleged herein, Defendants, individually and in furtherance of the fraudulent scheme alleged herein, made, or caused to be made, intentional misrepresentations of material facts relating to the claims they submitted or caused to be submitted to BCBS Georgia for reimbursement, with the intent to induce BCBS Georgia to rely on those misrepresentations and pay those claims.

256. Each Defendant knowingly participated in the fraud by agreeing to submit the claims to BCBS Georgia as if the underlying laboratory testing were performed at and by Chestatee.

257. Each Defendant's participation in the fraudulent scheme includes, but is not limited to, the following:

a. Chestatee: Durall Capital acquired Chestatee Regional Hospital in order to gain access to the hospital's participating status and favorable reimbursement rates with BCBS Georgia, both of which were

essential to the success of the scheme. Chestatee engaged the other Defendants, including Medivance, Reliance Labs, Neisha Carter Zaffuto, and Jorge Perez, to perform functions essential to the success of the scheme, and to use Chestatee's facility and billing information to submit the claims to BCBS Georgia. Chestatee used the on-site laboratory at Chestatee Regional Hospital as a front for its fraudulent scheme, and took steps to undermine BCBS Georgia's efforts to identify and stop the scheme. Chestatee conspired with the other Defendants to submit the claims at issue to BCBS Georgia while knowing that the claims contained material misrepresentations and omissions. In addition, when payment was made by BCBS Georgia, Chestatee shared such payment with the other Defendants, in exchange for their participation in the fraudulent scheme.

b. Reliance Labs: Reliance Labs engaged marketing personnel to drum up the test orders at issue. The tests were ordered from and completed by Reliance Labs. Reliance Labs reported the tests back to the ordering providers. Reliance Labs conspired with the other Defendants to submit the claims to BCBS Georgia as if the tests were ordered from and performed by Chestatee. When payment from BCBS Georgia was passed on by Chestatee to Reliance Labs, Reliance Labs used a portion of that

payment to fund kickbacks to referring providers.

c. Aaron Durall: Aaron Durall was responsible for the management of the scheme, and used his control over Chestatee (as CEO) and Reliance Labs (as President) to cause them to take the steps described above. Aaron Durall was primarily responsible for the Defendants' conspiracy to commit this fraudulent scheme, causing Chestatee and Reliance's agreement, hiring Jorge Perez, and engaging Medivance and Neisha Carter Zaffuto to participate as well. Aaron Durall created Durall Capital and, upon information and belief, arranged for its purchase of Chestatee Regional Hospital specifically to carry out this fraudulent scheme. Aaron Durall also hired a team of employees or agents of Reliance Labs, through which he supervised and directed the payment of kickbacks to referring providers in exchange for their patients' specimens. Further, upon information and belief, Aaron Durall has personally received a substantial portion of the amount paid by the BCBS Plans as a result of this fraudulent scheme.

d. Medivance: Medivance agreed with Chestatee, Reliance Labs, Aaron Durall, Jorge Perez, and Neisha Carter Zaffuto to prepare and submit claims to BCBS Georgia on behalf of Chestatee, in spite of the fact

that it knew the claims contained numerous material misrepresentations. Medivance worked closely with Chestatee and Aaron Durall to manage numerous functions of Chestatee Regional Hospital remotely from Florida (including billing and contracting with payors), in order to prevent on-site employees at Chestatee Regional Hospital and payors, including the BCBS Plans, from identifying this fraudulent scheme. When BCBS Georgia attempted to renegotiate its contracts with Chestatee to address the fraudulent scheme, Medivance sought to stop the contractual changes to perpetuate the fraudulent scheme. When BCBS Georgia implemented contractual and process changes to stop payment on claims stemming from this fraudulent scheme, Medivance modified its billing processes to evade those efforts, in spite of the fact that it knew the claims were fraudulent.

e. Jorge Perez: Aaron Durall retained Perez to help manage Chestatee's finances and billing services, and to assist with overall management of the scheme. Jorge Perez leveraged his healthcare experience to assist Aaron Durall in perpetrating the pass-through billing arrangement, including through Perez's company, Empower H.I.S., LLC. Upon information and belief, Perez provided financial assistance (directly

or indirectly) to Durall Capital and Aaron Durall's purchase of Chestatee Regional Hospital, with the expectation that the hospital would be used to perpetrate this pass-through billing scheme. Perez conspired with the other Defendants to submit the claims to BCBS Georgia in spite of the fact that he knew the claims contained numerous material misrepresentations. Further, upon information and belief, Jorge Perez has received a portion of the amount paid by the BCBS Plans as a result of this fraudulent scheme.

f. Neisha Carter Zaffuto: As President of Medivance, Neisha Carter Zaffuto was responsible for Medivance's agreement to submit the claims at issue to BCBS Georgia on behalf of Chestatee, in spite of the fact that she knew the claims were not payable by BCBS Georgia, were fraudulent, and were in violation of multiple contracts between BCBS Georgia and Chestatee Regional Hospital. After agreeing to participate in the scheme, Neisha Carter Zaffuto oversaw and directed Medivance's submission of fraudulent claims to BCBS Georgia on behalf of Chestatee, and caused Medivance to take the actions described above.

258. Collectively, Aaron Durall, Jorge Perez, and Neisha Carter Zaffuto directed the conduct of the remaining Defendants, thereby causing their agreement to submit the fraudulent claims to BCBS Georgia.

259. The claims submitted by Defendants, or that Defendants caused to be submitted, included the following material misrepresentations:

a. submission of the claims on a Form UB-04 (indicating that tests were conducted at a facility like a hospital, rather than at a standalone laboratory);

b. provider name (misrepresented as Chestatee);

c. provider street address (misrepresented as Chestatee);

d. provider Tax ID and NPI (misrepresented as Chestatee);

e. type of bill (misrepresented as "141," which represents a specimen submitted for analysis to a hospital, and later "131," which represents a hospital outpatient);

f. admission type (misrepresented as "2," which stands for "urgent" admission, when there was no admission);

g. source of admission (misrepresented as "9," which stands for "information not available," when there was no admission);

h. patient discharge status (misrepresented as "01," which represents a patient discharged to home or self-care, when there was no discharge);

i. attending physician and attending physician's NPI

(misrepresented referring provider as an attending physician); and

j. diagnosis code (misrepresented as "encounter for general adult medical examination without abnormal findings" in effort to avoid having claims identified as laboratory-related).

260. Defendants falsely certified, or caused Chestatee to falsely certify, that the billing information on each claim submitted to BCBS Georgia was "true, accurate, and complete" and that they "did not knowingly or recklessly disregard or misrepresent or conceal material facts."

261. Defendants also failed to disclose, or caused Chestatee to fail to disclose, material facts relating to the claims that Defendants submitted, or caused to be submitted, including that:

a. Chestatee, Medivance, Reliance Labs, Aaron Durall, Jorge Perez, and Neisha Carter Zaffuto had conspired to participate in a pass-through scheme in breach of Chestatee's HMO, PAR, and PPO Contracts with BCBS Georgia;

b. Aaron Durall and Reliance Labs paid kickbacks, or caused kickbacks to be paid, to referring providers or laboratories in exchange for their patient's specimens, resulting in those claims being billed to BCBS Georgia;

262. Defendants intentionally designed and operated their scheme to conceal from BCBS Georgia the identity of the laboratory performing the testing, as well as the identities of the participants in their conspiracy.

263. Defendants had a duty to disclose to BCBS Georgia information material to the claims that Defendants submitted, or caused to be submitted, to BCBS Georgia, so as not to mislead BCBS Georgia.

264. Defendants took on this obligation every time they filed a claim, or caused a claim to be filed, as they certified that the claim was not "knowingly or recklessly disregard[ing] or misrepresent[ing] or conceal[ing] material facts."

265. At the time that Defendants submitted the claims, or caused the claims to be submitted, they knew that the representations described above were false, and that the claims contained the above-described omissions.

266. These misrepresentations and omissions were material to BCBS Georgia's determination of whether the claims were payable.

267. Defendants intended for BCBS Georgia to rely on their material misrepresentations and omissions, such that BCBS Georgia would pay Chestatee for the claims arising from this pass-through scheme.

268. In failing to disclose the aforementioned material omissions to BCBS Georgia, Defendants acted in bad faith.

269. BCBS Georgia reasonably relied on the claims submitted to it by Defendants, including the misrepresentations and omissions, when determining whether to pay each claim.

270. Had BCBS Georgia been aware that the claims contained material misrepresentations, or omitted material information, it would not have made the payments it did.

271. Defendants had superior and special knowledge of their pass-through scheme, as set forth herein, and took steps to prevent BCBS Georgia from identifying the scheme.

272. As a result, when BCBS Georgia received the claims, it was unaware of the pass-through scheme, which was not reasonably discoverable by BCBS Georgia.

273. As a direct and proximate result of Defendants' material misrepresentations and omissions, the BCBS Plans have been damaged in an amount to be determined at trial.

COUNT VI
NEGLIGENT MISREPRESENTATION
(IN THE ALTERNATIVE TO COUNT V)
(Claims Paid under HMO & PAR Contracts – All Defendants; Claims Paid under PPO Contract – Jorge Perez Only)

274. The BCBS Plans incorporate by reference all preceding paragraphs

as if fully set forth herein and further allege as follows:

275. The claims submitted by Defendants, or caused to be submitted by Defendants, contained material misrepresentations, including but not limited to those described in paragraph 278, above.

276. These representations were either false, made without reasonable grounds for believing them to be true, made without knowledge of their truth or falsity, made without reasonable care, or made under circumstances in which Defendants ought to have known their falsity.

277. Defendants' misrepresentations were made to BCBS Georgia in the course of Defendants' business and because of a pecuniary interest.

278. Defendants had a duty to disclose to BCBS Georgia information material to the claims that Defendants submitted, or caused to be submitted, to BCBS Georgia, to avoid misleading BCBS Georgia.

279. Defendants took on this obligation every time they filed a claim, or caused a claim to be filed, as they certified that they were not "knowingly or recklessly disregard[ing] or mispresentin[g] or conceal[ing] material facts."

280. Defendants failed to exercise reasonable care when making these representations.

281. It was foreseeable that BCBS Georgia would rely on Defendants'

representations, given the nature of the claims payment process, and the fact that they were submitted to BCBS Georgia by Chestatee and Medivance.

282. BCBS Georgia reasonably relied on Defendants' representations, and paid the claims.

283. If BCBS Georgia had been aware of the material misrepresentations, BCBS Georgia would not have paid the claims.

284. As a direct and proximate result of Defendants' misrepresentations, the BCBS Plans have been damaged in an amount to be determined at trial.

COUNT VII
TORTIOUS INTERFERENCE WITH BCBS GEORGIA'S CONTRACTS WITH CHESTATEE
(Claims Paid under HMO & PAR Contracts – All Defendants Except Chestatee; Claims Paid under PPO Contract – Jorge Perez Only)

285. BCBS Georgia incorporates by reference all preceding paragraphs as if fully set forth herein and further alleges as follows:

286. BCBS Georgia has three valid and enforceable contracts with Chestatee (i.e., the PAR Contract, the HMO Contract, and the PPO Contract).

287. Through each of these Contracts, BCBS Georgia agreed to reimburse Chestatee only for services provided by Chestatee.

288. Similarly, each of the Contracts prohibited their assignment to third parties without BCBS Georgia's prior written approval.

289. By orchestrating and participating in the fraudulent scheme described herein, Reliance Labs, Medivance, Aaron Durall, Jorge Perez, and Neisha Carter Zaffuto caused Chestatee to breach its contracts with BCBS Georgia by, among other things:

a. Submitting claims to BCBS Georgia, or causing claims to be submitted to BCBS Georgia, for services not performed by, or performed under the direction and personal supervision of, Chestatee.

b. Submitting claims to BCBS Georgia, or causing claims to be submitted to BCBS Georgia, that Reliance Labs, Medivance, Durall, Perez, and Zaffuto knew were not accurate, complete, and truthful, including but not limited to claims containing the following misrepresentations:

i. Provider name;

ii. Provider street address;

iii. Provider Tax ID and NPI;

iv. Type of bill;

v. Admission type;

vi. Source of admission;

vii. Patient discharge status; and

viii. Attending physician and attending physician's NPI.

c. Assigning, delegating, subcontracting, or transferring the HMO and PAR Contracts or Chestatee's rights and responsibilities under the Contracts without the prior written consent of BCBS Georgia.

d. Submitting claims to BCBS Georgia, or causing claims to be submitted to BCBS Georgia, that Reliance Labs, Medivance, Durall, Perez, and Zaffuto knew were not reasonable and medically necessary, as defined by the Contract.

e. Paying, receiving, offering an incentive, or participating in an incentive program or arrangement that provides another physician or provider with a direct or indirect inducement to provide less than medically necessary health care services, supplies, accommodations, treatments or care to BCBS members.

290. Each of Aaron Durall, Jorge Perez, Neisha Carter Zaffuto, Medivance, and Reliance Labs was aware of these Contracts, including that the Contracts covered only services provided by Chestatee and were unassignable.

291. Upon information and belief, the reason that Aaron Durall and Durall Capital purchased Chestatee Regional Hospital was because of the hospital's agreements with payors, including with BCBS Georgia.

292. Similarly, the reason that Aaron Durall, Jorge Perez, Neisha Carter

Zaffuto, Medivance, and Reliance Labs agreed to this fraudulent scheme was because they knew that Chestatee's contracts with BCBS Georgia could be used to extract substantial reimbursement from BCBS Georgia, in exchange for which each of the Defendants would receive a portion of the reimbursement paid by BCBS Georgia.

293. In other words, Defendants agreed to participate in a fraudulent scheme that would cause Chestatee to repeatedly breach each of its three contracts with BCBS Georgia.

294. Defendants' collective efforts to disrupt BCBS Georgia's investigation of this fraudulent scheme demonstrates the Defendants' knowledge that their conduct was in violation of Chestatee's contracts with BCBS Georgia.

295. Reliance Labs, Medivance, Aaron Durall, Jorge Perez, and Neisha Carter Zaffuto improperly, wrongfully, willfully, and intentionally engaged in the fraudulent scheme described herein, thereby interfering with the HMO and PAR Contracts, and causing Chestatee to materially breach each of those Contracts.

296. Jorge Perez improperly, wrongfully, willfully, and intentionally engaged in the fraudulent scheme described herein, thereby interfering with the PPO Contract and causing Chestatee to materially breach that Contract.

297. The Defendants' interference with BCBS Georgia's contracts with Chestatee was not justified or privileged.

298. The Defendants' tortious interference with the contracts caused BCBS Georgia to pay for claims that were not payable by BCBS Georgia, were fraudulent, were in breach of the Contracts, and were otherwise unlawful.

299. But for the Defendants' tortious interference with the PAR, HMO, and PPO Contracts, BCBS Georgia would not have paid these claims.

300. The BCBS Plans are entitled to an award of compensatory damages, including consequential damages, together with interest and costs, and an injunction prohibiting Chestatee from continuing to engage in the tortious conduct described above.

COUNT VIII
RESTITUTION UNDER ERISA § 502(a)(3)
(Claims Paid under HMO & PAR Contracts – All Defendants;
Claims Paid under PPO Contract – Jorge Perez Only)

301. The BCBS Plans incorporate by reference all preceding paragraphs as if fully set forth herein and further allege as follows:

302. Many of the impacted group health plans are employer-sponsored group health plans covered by ERISA (the "ERISA Plans").

303. The BCBS Plans have been delegated by the plan administrator of each of the ERISA Plans the discretionary authority to review and decide on

claims for benefits under the ERISA Plans.

304. The ERISA Plans also delegated to the BCBS Plans the authority to recover overpayments made by the BCBS Plans on the ERISA Plans' behalf.

305. Because of the fraudulent scheme identified herein, the BCBS Plans have paid millions of dollars in benefits to Chestatee, and through Chestatee, to Reliance Labs, Medivance, Aaron Durall, Jorge Perez, and Neisha Carter Zaffuto.

306. The BCBS Plans have standing to sue under ERISA § 502(a)(3) to obtain appropriate equitable relief to redress violations of the ERISA Plans and to enforce the terms of the ERISA Plans.

307. As alleged herein, Defendants have submitted, or caused to be submitted, misleading and fraudulent claims to BCBS Georgia for payment of benefits for charges related to laboratory services that Defendants represented, or caused to be represented, were performed by Chestatee.

308. BCBS Georgia relied on the claim information supplied by Defendants, or that Defendants caused to be supplied, in determining whether to pay the claims.

309. Had BCBS Georgia been aware that the claims misrepresented the services in order to make them appear payable, when in fact they were not, it would not have made those payments.

310. Based upon the fraudulent claims Defendants submitted, or caused to be submitted, to BCBS Georgia, Defendants received payments in excess of the amounts that they were actually entitled to receive for those services.

311. Further, even if Defendants did not knowingly and intentionally submit misleading and fraudulent claims to BCBS Georgia, the BCBS Plans are entitled to equitable relief to enforce the terms of the ERISA Plans, and recover overpayments made to Defendants.

312. This is particularly true where Defendants submitted claims, or caused claims to be submitted, for members of ERISA Plans pursuant to valid contractual assignments (or authorized representation agreements) received from ERISA Plan members. In these instances, Defendants accepted the terms of the ERISA Plans and submitted claims, or caused claims to be submitted, that were subject to those terms.

313. Further, by knowingly accepting payments from the ERISA Plans, Defendants became bound by the ERISA Plans' terms and conditions, including conditions related to overpayments.

314. The ERISA Plans, by their terms, require the return of overpayments and amounts that were erroneously paid.

315. Thus, even to the extent that Defendants did not intentionally

overcharge BCBS Georgia, the BCBS Plans are entitled to equitable relief to enforce the terms of the ERISA Plans and recover these overpayments.

316. Because of Defendants' wrongful behavior, BCBS Georgia has paid millions of dollars in benefits to Chestatee, and, through Chestatee, to the other Defendants, which were not owed under the terms of the ERISA Plans.

317. Each Defendant has funds that they obtained in violation of the ERISA Plans' terms and conditions.

318. The BCBS Plans seek equitable restitution to cover the assets that Defendants unlawfully obtained because of the conduct described herein.

319. Specifically, the BCBS Plans seek an Order imposing a constructive trust or an equitable lien on the assets that Defendants received in the form of overpayments, as well as on any profits or income made by Defendants on those amounts.

320. The BCBS Plans also seek an Order restoring to the BCBS Plans—individually and on behalf of the ERISA Plans—the sums held in constructive trust by Defendants.

COUNT IX
DECLARATORY AND INJUNCTIVE RELIEF
UNDER ERISA § 502(a)(3) AND 28 U.S.C. §§ 2201 AND 2202
(Claims Paid under HMO & PAR Contracts – All Defendants;
Claims Paid under PPO Contract – Jorge Perez Only)

321. The BCBS Plans incorporate by reference all preceding paragraphs as if fully set forth herein and further allege as follows:

322. The BCBS Plans act as a claims fiduciary for the ERISA Plans.

323. Therefore, the BCBS Plans have standing to sue under ERISA § 502(a)(3) to enjoin any acts or practices that violate any provisions of the ERISA Plans, and to obtain other appropriate relief to redress such violations or enforce plan provisions.

324. Defendants have engaged in a scheme to defraud BCBS Georgia into paying amounts to Defendants in excess of amounts owed under the relevant ERISA Plans, and for services that are not covered under the relevant ERISA Plans' terms, as described herein.

325. There is an actual case and controversy between the BCBS Plans and Defendants as to the claims Defendants submitted, and continue to submit, to BCBS Georgia, all of which arise from the fraudulent scheme described herein.

326. Defendants' fraudulent scheme is deceptive, unfair, and unlawful.

327. No payment is due to Defendants on any claims that are pending, or may be submitted in the future, where such claims arise from Defendants' fraudulent scheme.

328. Defendants appear to disagree, and continue to submit fraudulent claims to BCBS Georgia.

329. There is a *bona fide*, present, and practical need for a declaration as to the lawfulness of Defendants' actions, including whether BCBS Georgia has the right to deny the claims implicated by Defendants' actions and scheme.

330. The BCBS Plans are entitled to a judgment declaring that Defendants' actions and business practices are unlawful, and that any claims for payment of benefits submitted by Defendants to BCBS Georgia because of this scheme are non-payable and void.

331. The BCBS Plans also seek recovery of their reasonable and necessary attorney's fees and costs, pursuant to ERISA § 502(g)(1).

332. Under the Declaratory Judgment Act, 28 U.S.C. §§ 2201 and 2202, the BCBS Plans are entitled to a judgment declaring that Defendants' actions and business practices are unlawful, even as to the non-ERISA plans impacted by this fraudulent scheme, and that any claims for payment of benefits submitted by Defendants as a result of their fraudulent scheme are non-payable and void.

COUNT X
UNJUST ENRICHMENT
(Claims Paid under HMO & PAR Contracts – All Defendants Except Chestatee; Claims Paid under PPO Contract – Jorge Perez Only)

333. The BCBS Plans incorporate by reference all preceding paragraphs as if fully set forth herein and further allege as follows:

334. Defendants fraudulently used the names and billing information of Chestatee to submit, or cause the submission of, claims to BCBS Georgia for services that were not performed at or by Chestatee, or on behalf of Chestatee patients.

335. BCBS Georgia, relying on Defendants' representations that the services billed for using Chestatee's name and billing information were performed at and by Chestatee on behalf of Chestatee patients, issued reimbursements to Chestatee, which were shared with the other Defendants.

336. Each Defendant received a benefit from the BCBS Plans in the form of a share of reimbursements for services that should not have been reimbursed.

337. Each Defendant has unjustly retained those benefits.

338. Each Defendant should be required to make restitution for the benefits they received, retained, and appropriated because justice and equity require such restitution.

339. Restitution is required by public policy to promote the stability of

insurance markets and to avoid the continuing unjust enrichment of unscrupulous providers at the expense of insurance companies and patients.

340. The BCBS Plans are entitled to restitution in an amount to be determined at trial, including but not limited to all amounts Defendants received from BCBS Georgia because of Defendants' scheme.

RELIEF REQUESTED

WHEREFORE, the BCBS Plans respectfully request an award in their favor and granting the following relief:

a) Actual and consequential damages in an amount to be determined at trial, plus interest;

b) An order obligating Defendants to disgorge all revenues and profits derived from their scheme;

c) An order holding Defendants jointly and severally liable;

d) An award of reasonable attorney's fees, in accordance with the relevant contracts or as allowed by common law;

e) Punitive damages;

f) Equitable relief, as described herein;

g) An injunction prohibiting Defendants from continuing the scheme;

h) Appropriate interim measures against Chestatee, Reliance Labs, Medivance, Aaron Durall, and Neisha Carter Zaffuto under American Arbitration Association Rule 37; and

i) Any other relief that the Court deems just, proper, and/or equitable.

Dated: December 28, 2018 By: *T. Joshua Archer*

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LOCAL RULE 7.1D CERTIFICATION

Through the signature below, counsel hereby certifies that the foregoing document was prepared in Book Antiqua, 13-point font, with lines double-spaced, in compliance with Local Rule 5.1C.

December 28, 2018

/s/ T. Joshua R. Archer
T. Joshua R. Archer (Ga. Bar No. 021208)

CERTIFICATE OF SERVICE

I hereby certify that I caused the foregoing to be electronically filed with the Clerk of Court using the CM/ECF system, which will automatically send notification to all counsel of record.

December 28, 2018

/s/ T. Joshua R. Archer
T. Joshua R. Archer (Ga. Bar No. 021208)

Exhibit A

Blue Cross Blue Shield of Georgia

PARTICIPATING HOSPITAL AGREEMENT

THIS AGREEMENT is effective on January 1, 1987 between BLUE CROSS AND BLUE SHIELD OF GEORGIA, INC. (the "PLAN") and St. Joseph Hospital of Dahlonega, Inc. ("HOSPITAL").

I. RECITALS

1.1- The PLAN is a Georgia non-profit health care corporation, duly licensed by the Insurance Commissioner of the State of Georgia, providing health care plans covering the provision of health care services.

1.2- HOSPITAL is a corporation, duly licensed by the State Department of Human Resources of the State of Georgia to provide quality acute inpatient and outpatient Hospital Services.

1.3- HOSPITAL provides Hospital Services that meet or exceed all legal standards of care and that comply: (a) with all applicable Federal, State and local laws, and (b) standards of the PLAN.

1.4- The PLAN and HOSPITAL are both committed to the delivery of quality health care services in an efficient and effective manner, recognizing the need to control and contain cost, and recognizing an obligation to maintain and improve health care.

NOW THEREFORE, in consideration of the promises and the Agreement herein contained, it is covenanted as follows:

II. DEFINITIONS

2.1- "Benefit Agreement(s)" means a written agreement entered into by the PLAN and employers, groups or individuals under which the PLAN or other Blue Cross and Blue Shield Plans provide, indemnify for, or administer health care benefits.

2.2- "Medical Emergency" means treatment for a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in: (a) Permanently placing the subscriber's health in jeopardy; (b) Serious impairment to bodily functions; (c) Serious and permanent disfunction of any bodily organ or part; or (d) Other serious medical consequences.

2.3- "Hospital Service(s)" means those acute inpatient services and outpatient services which are covered by the applicable Benefit Agreement. Hospital Services do not include skilled nursing or extended care services; however, such services are normally covered under the other professional and medical services section of the Subscriber Benefit Agreement.

2.4- "Medically Necessary" means Hospital Services or Medical Services as defined in Section 7.3 which the PLAN determines are covered under a Benefit Agreement.

2.5- "Medical Services" means those services provided by a physician (as defined by law) and covered under a Benefit Agreement.

2.6- "Identification Card" means the card issued by the PLAN identifying the Subscriber as entitled to receive services from HOSPITAL or any other eligible provider.

2.7- "Subscriber(s)" means any person entitled to receive the PLAN benefits for the services of HOSPITAL or other health care professionals, facilities or institutions as defined in and pursuant to a Benefit Agreement.

2.8- "Utilization Management Program(s)" means a function performed by the PLAN to review and determine whether the Hospital Services provided are covered and properly delivered under the Subscriber's Benefit Agreement.

2.9- "Covered Services" means those health care services and supplies for which Subscribers are entitled to receive benefits from the PLAN under a Benefit Agreement.

2.10- "Non-covered Services" means all health care services rendered to Subscribers other than Covered Services.

2.11- "Participating Hospital" means any licensed hospital which is a party to a Participating Hospital Agreement with the PLAN.

2.12- "Non-Participating Hospital" means any licensed hospital which is not a party to a Participating Hospital Agreement with the PLAN.

2.13- "Payment System" means a program developed by the PLAN to reimburse hospitals for Covered Services to Subscribers, which is attached hereto and made a part of this Agreement, hereinafter referred to as Exhibit A together with amendments thereto as from time to time adopted by the PLAN.

2.14- "Provider Audit" means the program developed by the PLAN to audit the charges of HOSPITAL to Subscribers for Hospital Services, which is attached hereto and made a part of this Agreement, hereinafter referred to as Exhibit B together with amendments thereto as from time to time adopted by the PLAN.

III. GENERAL PROVISIONS

3.1- The PLAN and HOSPITAL are independent entities. Nothing in this Agreement shall be construed or be deemed to create a relationship of employer and employee, or principal and agent, or any relationship other than that of independent parties contracting with each other solely for the purpose of carrying out the provisions of this Agreement.

3.2- HOSPITAL shall attain and maintain status as a Participating Hospital and meet all prerequisites associated therewith. Further, HOSPITAL shall display, in a prominent location in its admission lobby, the symbol of its participation in the form furnished by the PLAN.

3.3- HOSPITAL agrees that it will render Hospital Services to any Subscriber, insofar as its facilities and admission policies permit. When a patient of HOSPITAL has presented an Identification Card entitling the patient to benefits as a Subscriber under a Benefit Agreement issued by the PLAN, HOSPITAL will not require an advance deposit or solicit payment from such patient for Covered Services, except for any deductibles or coinsurance that are the Subscriber's responsibility under the Benefit Agreement.

3.4- This Agreement is entered into by HOSPITAL and the PLAN with the express understanding and agreement that this Agreement shall not be construed nor considered to be an Agreement between HOSPITAL and other hospitals who are party to similar Agreements. This Agreement shall not constitute an Agreement that HOSPITAL may act as agent for any other hospital that becomes a party to a similar Agreement. This Agreement shall not impose any liability upon any other hospital by reason of any act or acts of omission or commission on its part, nor shall HOSPITAL incur any liability by reason of any act or acts of omission or commission of any other hospital.

3.5- HOSPITAL agrees to indemnify and hold the PLAN harmless from any and all liability, loss, damage, claim or expense of any kind, including costs and attorneys' fees, which result from any action or proceeding involving alleged medical liability by HOSPITAL, its agents or employees.

3.6- It is understood the PLAN retains the right to change, revise, modify or alter the form and content of any Benefit Agreement without prior approval or notice to the HOSPITAL.

IV. HOSPITAL SERVICES AND RESPONSIBILITIES

4.1- HOSPITAL shall provide Medically Necessary Hospital Services to Subscribers as provided in the applicable Benefit Agreement when ordered by a licensed physician or other licensed medical professionals and are within the bylaws of the HOSPITAL.

4.2- HOSPITAL shall provide Hospital Services to Subscribers in the same manner as those services are provided to all other patients at HOSPITAL. The quality of Hospital Services shall be no less than the quality of services provided to other patients at HOSPITAL.

4.3- HOSPITAL has, and shall maintain in good standing, all licenses required by law. Evidence of such licenses shall be submitted to the PLAN upon request.

4.4- In order to encourage HOSPITAL to satisfy recognized mimimum standards in providing patient care, HOSPITAL agrees to be either accredited by the Joint Commission on Accreditation of Hospitals (JCAH) or the American Osteopathic Association (AOA), or certified for the Medicare Program through the Health Care Financing Administration, Division of Health Standards and Quality, as applicable. After a decision by JCAH or AOA to deny accreditation or by the Health Care Financing Administration, Division of Health Standards and Quality, to deny a certification to HOSPITAL, the PLAN shall have the right, notwithstanding any other provision contained herein, to terminate this Agreement upon giving HOSPITAL thirty (30) days prior written notice of such intent to terminate. Such notice to terminate will be stayed if HOSPITAL initiates an appeal of such a decision or applies for an alternative certification or accreditation within the thirty (30) day period stated in the PLAN'S notice. After a final decision to deny certification or accreditation, the PLAN shall have the right, notwithstanding any other provision contained herein, to terminate this Agreement upon giving HOSPITAL thirty (30) days prior written notice of such intent to terminate.

4.5- HOSPITAL shall ensure that all physicians and other medical professionals who practice at HOSPITAL, whether or not on its medical staff, and all employees continue to meet all applicable State laws and regulations, and all rules of HOSPITAL and medical staff.

4.6- HOSPITAL shall promptly notify the PLAN of: (a) Any action against any of its licenses; (b) Any changes in its ownership or business address; (c) Any legal or government action, other problem or situation that in the opinion of the Chief Executive Officer might impair the ability of HOSPITAL to carry out its duties and obligations under this Agreement.

4.7- HOSPITAL agrees to permit the PLAN to conduct Provider Audits and Utilization Management Program audits. In addition HOSPITAL agrees to permit such other activities as are deemed mutually necessary to ensure correct payment to HOSPITAL for Covered Services rendered to a Subscriber.

V. THE PLAN SERVICES AND RESPONSIBILITIES

5.1- The PLAN agrees to pay HOSPITAL directly for Covered Services rendered to Subscribers pursuant to the provisions of Article VI, Exhibit A and other applicable provisions of this Agreement.

5.2- The PLAN agrees to grant HOSPITAL the status of "Participating Hospital," and to identify HOSPITAL as a Participating Hospital on informational materials to Subscribers.

5.3- The PLAN agrees to continue listing HOSPITAL as a Participating Hospital until this Agreement terminates.

5.4- The PLAN shall make payments to HOSPITAL under this Agreement as provided by Georgia law within fifteen (15) working days of receipt of bills (either paper claims or the PLAN paperless claims entry system) from HOSPITAL, provided that such bills are accurate, complete, and properly itemized.

5.5- The benefits to which a Subscriber shall be entitled shall be limited to those set out in that Subscriber's Benefit Agreement in effect at the time Covered Services are performed, and the PLAN shall not be responsible for any misrepresentation of the Benefit Agreement made to HOSPITAL by Subscriber; provided, however, that (a) HOSPITAL shall be entitled to rely on that Subscriber's Identification Card, when presented to HOSPITAL, as to the accuracy of all information contained therein and (b) the PLAN, upon request by HOSPITAL (either by telephone or in writing), shall verify and confirm the Subscriber's membership. The PLAN shall be responsible for any discrepancies between the information so verified and confirmed and such Subscriber's Benefit Agreement.

5.6- The PLAN shall provide timely management reports to the Chief Executive Officer of the HOSPITAL containing data determined by the PLAN to be relevant to operation of the Payment System described in Exhibit A.

5.7- The PLAN agrees to provide HOSPITAL with a list of all participating physicians, participating hospitals, and other participating providers which are located within a reasonable geographic area to the HOSPITAL.

VI. COMPENSATION AND BILLING

6.1- HOSPITAL agrees that the only charges for which Subscribers may be liable and be billed by HOSPITAL shall be for Hospital Services not covered under an applicable Benefit Agreement and for deductibles and co-insurance as provided in that Benefit Agreement. The Subscriber may not be billed for the difference between billed charges and the Payment Adjustment described in Exhibit A.

6.2- HOSPITAL shall bill the PLAN in a manner and on forms acceptable to the PLAN (currently UB-82 paper claim form or the PLAN paperless claims entry system) and on a periodic basis as prescribed by the PLAN from time to time. HOSPITAL shall furnish, on request, all information reasonably required by the PLAN to verify and substantiate the provision of Hospital Services and the charges for such services. Such bills should be submitted within sixty (60) days after the services are rendered, but in no instance can the bill be submitted later than twelve (12) months from the date the services are rendered. The PLAN reserves the right to review all statements submitted by HOSPITAL. Claims which are not submitted within the timely filing period described above will not be honored and HOSPITAL agrees not to bill Subscribers or the PLAN for services associated with such claims. The PLAN will not apply this provision to any claim in which the PLAN was the cause of the delay.

6.3- The PLAN agrees to reimburse HOSPITAL for Hospital Services provided to Subscribers regarding inpatient admissions and outpatient claims as set forth in Exhibit A attached to and made a part of this Agreement.

6.4- The PLAN shall be permitted to recover from HOSPITAL amounts due the PLAN because of (a) payments made in error, (b) the Utilization Management Program, (c) the Payment System described in Exhibit A, (d) the Provider Audit program described in Exhibit B or (e) inaccurate payments including payments based upon erroneous or incomplete information provided by HOSPITAL. HOSPITAL shall first be given an opportunity to refund the amount. If this recovery is not received within forty-five (45) days of the notice from the PLAN, then the PLAN shall have a right to offset, deducting from future payments, amounts due the PLAN. The PLAN shall provide adequate notice to HOSPITAL of the amounts offset.

Examples of "payments made in error" include but are not limited to:

(a) Duplicate Payments: when two or more payments have been made to the HOSPITAL for the same service rendered the same Subscriber on the same day;

(b) Services not Rendered: when payments have been made to the HOSPITAL for services not rendered by the HOSPITAL;

(c) Non-covered Services: when the PLAN has made a payment for services later determined by the PLAN to be non-covered;

(d) Coordination of Benefits: when the PLAN is the secondary carrier under the coordination of benefits provision of a Benefit Agreement and has made a payment for services for which payment has been or should have been made by a primary carrier; or

(e) Workers' Compensation: when payment has been made by the PLAN for services for which benefits are available to the Subscriber under the Workers' Compensation laws of any state or federal jurisdiction.

6.5- The PLAN shall make refunds to HOSPITAL for amounts due HOSPITAL because of (a) omissions and underpayments of bills made in error, (b) the Payment System described in Exhibit A, and (c) the Provider Audit program described in Exhibit B. These refunds shall be made within forty-five (45) days of written notice given by HOSPITAL.

6.6- The provisions of this Agreement shall apply only to the number of HOSPITAL'S beds licensed by the State of Georgia recorded with the PLAN.

6.7- The day of Hospital Service is defined to mean the period or any parts thereof between the census-taking hours of two successive days. The Census-taking Hour is defined to be the hour fixed by the HOSPITAL for counting its patients. In computing the number of days of Hospital Services furnished, the day of admission shall be counted, but the day of discharge shall not be counted unless the Subscriber is discharged on the day of admission.

6.8- Changes in HOSPITAL charges shall be reported to the PLAN in the format attached hereto and made a part of this Agreement, hereinafter referred to as Exhibit C. Changes in charges will be made on the effective date requested by HOSPITAL provided changes are not retroactive. The PLAN reserves the right to negotiate charges with any Hospital attempting to compromise the Payment System. Disputes regarding this issue will be reconciled under the Dispute Resolution clause in Article X. The HOSPITAL agrees to supply to the PLAN a schedule of all charges upon request.

6.9- The PLAN agrees to provide HOSPITAL with a copy of its certified annual financial statements within thirty (30) days of completion. In exchange HOSPITAL shall provide the PLAN with a copy of its certified annual financial statements upon request.

6.10- The HOSPITAL agrees that the PLAN shall never be charged a fee or rate higher than that charged for services to the general public, and that the PLAN will be billed on the same billing system as the HOSPITAL utilizes for the general public.

6.11- The PLAN and HOSPITAL both recognize the need to coordinate the replacement or expansion of HOSPITAL facilities with the overall plans for hospital facilities developed by the highest recognized statewide governmental planning agency. The purpose of this coordination is to eliminate unnecessary and duplicate facilities. Beginning with the date on page 1 of this Agreement, if the highest recognized statewide governmental planning agency disapproves a project relative to HOSPITAL that is subject to its review and if that decision is not subsequently reversed by higher authority or if such approval is obtained initially or thereafter is reversed by higher authority all as provided by law, and HOSPITAL nevertheless carries out the project for which no endorsement is in force, the PLAN payment to HOSPITAL with respect to that project will be computed without allowance for capital expenditures applicable to such project.

VII. UTILIZATION MANAGEMENT

7.1- The PLAN shall establish a Utilization Management Program. HOSPITAL agrees to cooperate with and be bound as between HOSPITAL and the PLAN, by the determinations of any Utilization Management Program.

7.2- Utilization Management Programs conducted by the PLAN shall determine Covered Services under the Subscriber's Benefit Agreement. Reviews and determinations include but are not limited to the appropriateness of acute hospitalization, length of stay, outpatient care, or diagnostic services. This function would also include review for Non-covered Services such as pre-existing conditions, cosmetic procedures and custodial care.

7.3- The PLAN and the HOSPITAL agree to attempt to avoid retrospective denial of Hospital Services as much as possible in all Utilization Review Procedures, and to seek to minimize this occurrence. The PLAN reserves the right to determine whether in its judgement a service or supply is Medically Necessary. The fact that a physician has ordered a service or supply does not, in itself, make it Medically Necessary. Medically Necessary Hospital Services are: (a) consistent with the symptom or diagnosis and treatment of the condition, disease, ailment, or injury; and (b) not primarily for the convenience of the Subscriber, his or her Physician, or other provider, and not primarily custodial care.

7.4- The PLAN shall not be obligated to pay for Hospital Services provided to a Subscriber after the attending physician determines that further hospitalization is not Medically Necessary, or if the Hospital's utilization review

committee determines that further hospital care is not Medically Necessary. Hospital shall not charge Subscribers for Hospital Services denied by the PLAN as not being Medically Necessary, unless HOSPITAL notifies Subscriber in writing such Hospital Services are not reimbursable by the PLAN and Subscriber agrees in writing to reimburse HOSPITAL directly for such Hospital Services.

7.5- HOSPITAL agrees to cooperate with the PLAN in administering special "Utilization Management Programs" which specific PLAN accounts may require and/or purchase from the PLAN. These programs may include, but are not limited to:

(a) "Pre-admission Certification" to determine the appropriateness of the inpatient admission.

(b) "Admission Review" to determine whether an unscheduled inpatient admission or an admission not subject to pre-admission review was medically necessary.

(c) "Concurrent Review" to determine whether a continued inpatient hospital stay is Medically Necessary.

7.6- Utilization Management shall include medical review of claims in order to determine Non-covered Services such as cosmetic procedures, custodial care and pre-existing conditions. (Pre-existing conditions are defined in the Subscriber's Benefit Agreement.) The PLAN reserves the right to deny payment for any Hospital Service(s) the PLAN determines to be Non-covered Services. The decision of the PLAN is final for the medical review of individual claims. HOSPITAL has the right to bill Subscriber directly for any charges determined by the PLAN as Non-covered Services.

7.7- HOSPITAL may appeal any Utilization Management denial in which the HOSPITAL is not permitted to bill the Subscriber by requesting reconsideration by the Health Cost Management Division of the PLAN within thirty (30) days following communication of such denial to the HOSPITAL. Such reconsideration shall be conducted and the reconsideration decision shall be communicated to the HOSPITAL. If HOSPITAL is not satisfied with the result of the Health Cost Management Division, HOSPITAL may request arbitration by an independent professional review agency with whom the PLAN has contracted. HOSPITAL and the PLAN agree that the decision of the independent professional review agency is binding on both parties.

7.8- The PLAN shall rely on the HOSPITAL'S Utilization Review Committee for concurrent utilization review. HOSPITAL agrees to submit to the PLAN its utilization review plan upon request. HOSPITAL further agrees to submit any changes or modifications of its utilization review plan to the PLAN upon request.

VIII. RECORDS, MAINTENANCE, AVAILABILITY, INSPECTION AND AUDIT

8.1- HOSPITAL shall prepare and maintain all appropriate records on Subscribers receiving Hospital Services at HOSPITAL. The records shall be maintained in accordance with generally accepted record-keeping procedures and as required by law.

8.2- Ownership and access to HOSPITAL'S records of Subscribers shall be controlled by applicable Federal, State and local laws and this Agreement.

8.3- HOSPITAL agrees to permit reasonable inspection and reasonable audit, and provide reasonable duplication of data and other records referred to in Section 8.1, including but not limited to billing, payment, assignment, Utilization Management, and medical records maintained on Subscribers pursuant to this Agreement. Such inspection, audit and duplication shall be provided upon reasonable notice during regular business hours, and shall be provided without cost to the PLAN or Subscriber. PLAN agrees to request the minimum number of records necessary to reasonably fulfill its obligations under this contract with the HOSPITAL and Subscriber.

8.4- HOSPITAL and PLAN agree to keep confidential, and to take all reasonable precautions to prevent the unauthorized disclosure of any and all records required to be prepared or maintained by this Agreement.

IX. MARKETING, ADVERTISING AND PUBLICITY

9.1- The PLAN shall have the right to use the name of HOSPITAL for purposes of marketing, informing Subscribers of the identity of Participating Hospitals, and otherwise to carry out the terms of this Agreement.

9.2- Except as provided in Section 9.1, the PLAN and HOSPITAL each reserves the right and control of the use of its name, symbols, trademarks and service marks presently existing or later established. In addition, except as provided in Section 9.1, neither the PLAN nor HOSPITAL shall use the other party's name, symbols, trademarks or service marks in advertising or promotional material or otherwise without the prior written consent of that party and shall cease any such usage immediately upon written notice of that party or upon termination of this Agreement, whichever is sooner.

X. DISPUTE RESOLUTION

10.1- The PLAN and HOSPITAL agree to meet and confer in good faith to resolve any problems or disputes that may arise under this Agreement.

10.2- In the event that any problem or dispute, other than a Utilization Management decision provided for in Article VII, is not satisfactorily resolved, the PLAN and HOSPITAL agree to submit the problem or dispute to the Hospital Service Committee of the Board of Directors of the PLAN for resolution. Either party may initiate the action. The Hospital Service Committee shall hold a hearing and decide the matter within sixty (60) days thereafter.

10.3- Either party may appeal the Hospital Service Committee decision to the Board of Directors of the PLAN by giving written notice to the other party and the PLAN within ten days following the date of the Hospital Service Committee decision. The decision of the Board of Directors shall be final and binding on both parties.

XI. TERM AND TERMINATION

11.1- When executed by both parties, this Agreement shall become effective as of the date noted on page 1 and shall continue in effect until terminated.

11.2- Either party may terminate this Agreement, with or without cause, by giving prior written notice of at least ninety (90) days. Nothing contained in this Agreement shall be construed to limit either party's lawful remedies in the event of a material breach of this Agreement.

11.3- If this Agreement be terminated pursuant to this Article XI, HOSPITAL shall continue to provide Hospital Services under the terms of this Agreement to Subscribers who are hospital inpatients on the date of termination until those Subscribers are discharged.

11.4- Notwithstanding termination, the PLAN shall continue to have access to records for three (3) years, in accordance with Article VIII, to the extent permitted by law and as necessary to fulfill the terms of this Agreement.

11.5- After the effective date of termination, this Agreement shall remain in effect for the resolution of all matters unresolved on the date of termination.

11.6- This Agreement will automatically terminate upon the suspension or revocation of the HOSPITAL'S license to operate, or a change of ownership of the HOSPITAL.

XII. UNFORESEEN CIRCUMSTANCES

12.1- In the event that the operations of HOSPITAL'S facilities are substantially interrupted by acts of war, fire, insurrection, labor disputes, riots, earthquakes, or other acts of nature, HOSPITAL shall be relieved of its obligations only as to those affected operations and only as to those affected portions of this Agreement for the duration of such interruption.

12.2- In the event that the Hospital Services provided by HOSPITAL are substantially interrupted pursuant to an event described in Section 12.1, the PLAN shall have the right to terminate this Agreement upon thirty (30) days prior written notice to HOSPITAL. Such notice of termination shall be withdrawn if the PLAN in its judgement determines that Hospital Services can be performed in spite of the event or because the interruption has ended.

XIII. MISCELLANEOUS PROVISIONS

13.1- No assignment of the rights, duties, or obligations of this Agreement shall be made by HOSPITAL. Any attempted assignment in violation of this provision shall be void as to the PLAN.

13.2- HOSPITAL shall not subcontract this Agreement or any portion of it without prior written consent of the PLAN.

13.3- Waiver of a breach of any provision of this Agreement shall not be deemed a waiver of any other breach of the same or different provision.

13.4- Any notices required to be given pursuant to the terms and provisions of this Agreement shall be in writing and shall be sent by certified mail, return receipt requested, postage prepaid, to the PLAN at:

BLUE CROSS AND BLUE SHIELD OF GEORGIA, INC.; 3348 PEACHTREE ROAD, N.E.; ATLANTA, GA 30326; ATTENTION: SENIOR VICE PRESIDENT, HEALTH CARE AFFAIRS;

and to HOSPITAL at the address shown on the application form submitted by the HOSPITAL. The notice shall be effective on the date indicated on the return receipt.

13.5- In the event any provision of this Agreement is rendered invalid or unenforceable by any federal statute or state law, or by any regulation duly promulgated by officers of the United States or of the State of Georgia acting in accordance with law, or declared null and void by any court of competent jurisdiction, the remaining provisions of this Agreement shall, subject to Section 13.6, remain in full force and effect.

13.6- In the event that a provision of this Agreement is rendered invalid or unenforceable or declared null and void as provided in Section 13.5 and its removal has the effect of materially altering the obligations of either party in such manner as in the judgement of the party affected (a) will cause serious financial hardship to such party, or (b) will cause such party to act in violation of its corporate Articles or Bylaws, the party so affected shall have the right to terminate this Agreement upon thirty (30) days prior written notice to the other party. The applicable provisions of Article XI shall apply to such termination.

13.7- The PLAN may amend this Agreement from time to time; such amendment shall automatically become part of this Agreement ninety (90) days after written notice of the amendment has been sent to the HOSPITAL.

13.8- The headings of Articles and Sections contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

13.9- This Agreement shall be construed and enforced in accordance with the laws of the State of Georgia.

13.10- In the event that either the PLAN or HOSPITAL institutes any action, suit, or arbitration proceeding to enforce the provisions of this Agreement, the prevailing party shall recover its costs and reasonable attorneys' fees.

13.11- This Agreement replaces and supersedes all prior Participating Hospital Agreements between the HOSPITAL and the PLAN, but does not affect any other agreements between the parties.

HOSPITAL	BLUE CROSS AND BLUE SHIELD OF GEORGIA, INC.
For: SAINT JOSEPH'S HOSPITAL OF DALTON GA, INC. (Name of Hospital)	By: Thomas Kinser (Signature)
By: (Signature)	Thomas Kinser (Name Printed)
TOMMY C. REDDIN (Name Printed)	President and CEO (Title)
V/P - C.O.O. (Title)	October 15, 1986 (Date)
December 30, 1986 (Date)	Attested By: (Corporate Secretary or Assistant Secretary)

EXHIBIT A TO THE PARTICIPATING HOSPITAL AGREEMENT

PLAN PAYMENT SYSTEM

I. DEFINITIONS

1- "Peer Group" - A grouping of hospitals by the PLAN using criteria established by the PLAN.

2- "Diagnosis Related Grouping (DRG)" - A method of classifying hospital patients by similar diagnoses, procedures, age, sex, and discharge status.

3- "Principal Diagnosis" - The condition established after study to be chiefly responsible for occasioning the admission of the patient to the HOSPITAL for care.

4- "Other Diagnosis" - All conditions (secondary) that exist at the time of admission or develop subsequently which affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on this hospital stay are to be excluded (includes complications and co-morbidities).

5- "Principal Procedure" - The procedure which was performed for definitive treatment rather than one performed for diagnostic or exploratory purposes, or was necessary to take care of a complication. The principal procedure is that procedure most related to the principal diagnosis.

6- "Inlier" - Patient stays which meet the criteria for being assigned to a DRG and which do not present any of the factors which would cause the patient stay to be considered an Outlier.

7- "Outlier" - Patient stays which have unique characteristics and are considered to be outside established parameters for each DRG. Outliers consist of cases with any of the following characteristics:

(a) Length of stay above trim points specified by the PLAN, (b) Charges above trim points specified by the PLAN, and (c) Patients whose diagnosis does not group into valid DRG's (currently DRG codes 468-470).

8- "Hospital Based Physician Charges" - Physicians who are independent practitioners, whose services are billed by HOSPITAL to the PLAN as a part of the Subscriber's total bill.

9- "Average Charge Per Admission" - HOSPITAL'S average inpatient charge per admission for claims paid during the previous twelve-month Data Collection Period as calculated by the PLAN for all Inliers. For the first year of this Agreement, the Data Collection Period may be less than twelve months.

10- "Adjusted Charge Per Admission" - Each Participating Hospital's average inpatient charge per admission as calculated by the PLAN after adjustments for Case Mix Complexity and Hospital Based Physician Charges.

11- "Payment Threshold" - The limit for the Adjusted Charge Per Admission set each year by the PLAN for each Peer Group.

12- "Inflation Index" - The index(es) which the PLAN will use each year to inflate the Payment Threshold.

13- "Case Mix Complexity Index" - An index calculated by the PLAN for the HOSPITAL based on HOSPITAL'S PLAN admissions (Inliers) grouped by DRG.

14- "Payment Adjustment" - The percentage calculated each year by the PLAN for any Participating Hospital whose Adjusted Charge Per Admission is greater than its Peer Group's Payment Threshold. This percentage will be derived by dividing the Peer Group Payment Threshold by HOSPITAL'S Adjusted Charge Per Admission. The Payment Adjustment will be applied to all HOSPITAL inpatient claims submitted during the Payment Period.

15- "Data Collection Period" - The twelve-month claims payment period (currently October 1 to September 30) used to compare Participating Hospital charges for PLAN admissions.

16- "Payment Period" - The twelve-month period (currently January 1 to December 31) during which the PLAN will pay HOSPITAL using the HOSPITAL'S Payment Adjustment for any inpatient claim submitted by HOSPITAL.

17- "Trim Points" - The respective limits set by the PLAN on length of stay and charges per admission. If the inpatient's length of stay or charges are above the respective Trim Point, the admission is considered an Outlier.

II. PAYMENT

1- The PLAN agrees to reimburse HOSPITAL for Hospital Services provided to Subscribers regarding outpatient claims at reasonable billed eligible charges.

2- If HOSPITAL has under $100,000 in total inpatient charges for PLAN Subscribers for each of the previous two twelve-month Data Collection Periods, PLAN will pay HOSPITAL its reasonable billed eligible charges.

3- If HOSPITAL has over $100,000 in total inpatient charges for PLAN Subscribers for any one of the previous two twelve-month Data Collection Periods, PLAN will pay HOSPITAL for Subscriber Hospital Services according to the provisions of Sections 4 thru 12 of this Article II.

4- Each year the PLAN will calculate each Participating Hospital's Payment Adjustment with data from the prior twelve-month Data Collection Period using the procedures described in this Exhibit A.

5- The PLAN will first calculate for HOSPITAL an Average Inpatient Charge Per Admission.

6- The PLAN will subtract Hospital Based Physician Charges from the HOSPITAL Average Charge Per Admission for comparison purposes.

7- The Average Charge Per Admission will be further adjusted by the HOSPITAL'S Case Mix Complexity Index. The result will be the HOSPITAL'S Adjusted Charge Per Admission.

8- All Participating Hospitals will be grouped into homogeneous Peer Groups by the PLAN.

9- In the first and second years of the Agreement the PLAN will calculate a Payment Threshold for each Peer Group. The Payment Threshold for the first and second years for each Peer Group will be greater than the average of the Adjusted Charge Per Admission for each respective Peer Group.

10- After the second year of the Agreement the Payment Threshold for each succeeding year will be set by inflating the previous Payment Threshold by the Inflation Index.

11- The Payment Threshold will be the maximum Adjusted Charge Per Admission which the PLAN will pay as determined for each Peer Group.

(a) Participating Hospitals whose Adjusted Charge Per Admission is less than their respective Peer Group's Payment Threshold will be paid reasonable billed eligible charges for the succeeding twelve-month Payment Period.

(b) Participating Hospitals whose Adjusted Charge Per Admission is greater than their respective Peer Group's Payment Threshold will have a Payment Adjustment calculated by the PLAN. The Payment Adjustment will be the percentage calculated by dividing the Peer Group Payment Threshold by the HOSPITAL'S Adjusted Charge Per Admission. This Payment Adjustment will be the PLAN'S basis of payment to HOSPITAL for inpatient admissions for the succeeding twelve-month Payment Period. A patient cannot be considered an inpatient and outpatient on the same calendar day.

12- The PLAN agrees to supply HOSPITAL with its Payment Adjustment 60 days prior to the beginning of the new Payment Period.

III. INFORMATION

1- In order for the PLAN to assign a DRG number to each admission, HOSPITAL shall provide the following information for each Subscriber admission:

(a) Principal diagnosis and any other diagnoses (using the ICD-9-CM coding system), (b) principal procedures and any other procedures (using the ICD-9-CM coding system), (c) age on admission, (d) sex, and (e) discharge status.

2- In the event HOSPITAL submits an interim bill while the Subscriber is still an inpatient, the PLAN will use the information submitted at discharge to assign the DRG.

3- Each year HOSPITAL agrees to provide to the PLAN any data needed for calculating the average Hospital Based Physician Charges per Subscriber admission. The PLAN shall provide HOSPITAL with a description of the information needed and the date by which data is needed (currently October 5).

4- HOSPITAL agrees to notify the PLAN of any changes in its billing practices for Hospital Based Physicians.

5- The PLAN shall have the right to conduct on-site audits to verify DRG assignment criteria and Hospital Based Physician Charges.

6- Any HOSPITAL dispute for any portion of this Payment System shall first be sent to the Health Care Affairs Division of the PLAN for reconsideration. If HOSPITAL is not satisfied with the result of such consideration, HOSPITAL may follow the Dispute Resolution procedure described in Article X of the Agreement.

EXHIBIT B OF THE PARTICIPATING HOSPITAL AGREEMENT

PROVIDER AUDITS

1- The PLAN shall be given the right by the HOSPITAL to conduct on-site audits during the HOSPITAL'S regular business hours. These audits shall consist of, but are not limited to, the examination of appropriate records to verify that the charges on the hospital bill are for services ordered by a physician and rendered to the patient, and that the charges are accurate.

2- The HOSPITAL agrees, upon request and at a time mutually agreed upon by the HOSPITAL and the PLAN, to make available for audit to authorized representatives of the PLAN any medical records, statement-of-charge records, and any supporting documents covering Hospital Services to a Subscriber. PLAN agrees that each Subscriber, as a condition of enrollment in the PLAN, will have authorized such disclosure of information.

3- The PLAN agrees that all representatives conducting Provider Audits on site at the HOSPITAL shall carry identification designating them as PLAN personnel.

4- The HOSPITAL shall permit authorized representatives of the PLAN to examine and audit all records, documents, and data pertinent to the PLAN claims at the HOSPITAL.

5- The PLAN reserves the right to compile pertinent data/documents regarding Provider Audits as determined to be appropriate and sufficient for reporting audit findings, while respecting patient confidentiality.

6- No audit charge or fee shall be billed to the PLAN or Subscriber by the HOSPITAL regarding copies of records or documents or the use of HOSPITAL personnel in supplying needed audit documentation.

7- The PLAN will make reasonable Provider Audit requests and conduct the audits in an expeditious and professional manner in order to minimize disruptions and burdens to the HOSPITAL.

8- The PLAN agrees there will be no unneccesary delays in claim payments to HOSPITAL because of Provider Audits.

9- Terms covering payments of refunds due HOSPITAL by PLAN, or PLAN by HOSPITAL, as a result of Provider Audit findings are described in Section 6.4 of the Agreement. The PLAN agrees to reimburse HOSPITAL, upon receipt of an adjusted bill, for properly documented Hospital Services provided to the Subscriber and not billed by HOSPITAL discovered in the course of a Provider Audit.

10- HOSPITAL agrees not to bill Subscriber for any refund HOSPITAL makes to the PLAN as a result of any Provider Audit(s).

11- No routine adjustments will be projected from a routine claims audit sample except under special circumstances. For example, where a specific problem can be identified as a result of Provider Audits, projection of an adjustment may well be considered statistically valid. If the HOSPITAL objects to such a projection, it may request that an extended claims audit be performed, and the amount of the adjustment will be projected from this extended audit. If the PLAN determines that immediate repayment will cause undue financial hardship for the HOSPITAL, the HOSPITAL and the PLAN may agree to a repayment schedule which satisfies the specific adjustment.

12- The PLAN representatives will not receive any part of any amounts recovered.

13- If HOSPITAL has concerns regarding the auditor's experience or conduct, or excessive document requests resulting in an unreasonable economic burden, HOSPITAL may state its grievance and request relief by petitioning the Health Care Affairs Division of the PLAN. The PLAN decision shall be communicated to the HOSPITAL. If HOSPITAL is not satisfied with the Health Care Affairs Division decision, HOSPITAL may follow the dispute resolution procedures described in Article X of the Agreement.

14. In addition, Provider Audits hereunder shall be conducted pursuant to the following:

(a) The PLAN will furnish a written notice of an on-site Provider Audit to HOSPITAL prior to the visit defining the nature of the audit.

(b) The on-site review will be conducted by qualified PLAN personnel who are familiar with medical terminology and general hospital charging and medical record documentation procedures.

(c) The PLAN personnel will schedule an entrance conference with appropriate HOSPITAL staff to coordinate arrangements for the Provider Audit and an exit conference to discuss the results of the Provider Audit.

(d) HOSPITAL agrees to work with the PLAN in instituting corrective action to reconcile billing and documentation problems. The PLAN agrees to inform HOSPITAL of PLAN policies and billing guidelines in order to prevent future incorrect payments.

EXHIBIT C C. THE PARTICIPATING HOSPITAL AGREEMENT

SCHEDULE OF ROOM RATE CHANGES

HOSPITAL NAME: SAINT JOSEPH'S HOSPITAL OF DAHLONEGA DATE COMPLETED: 12/30/86

ADDRESS: 1111 MOUNTAIN DR.

CITY: DAHLONEGA STATE: GA ZIP CODE: 30533 TELEPHONE NO: (404)-864-6136

PERSON REPLYING & TITLE: TOMMY G. REDDIN, C OO

BLUE CROSS PROVIDER #: 278 EFFECTIVE DATE: MARCH 1, 1987

		MEDICAL & SURGICAL			PSYCH	REHAB	DE-TOX		TOTAL
ONE-BED ROOMS	Number of Beds	18							
	Rate	$ [redacted]	$	$	$	$	$	$	
TWO-BED ROOMS	Number of Beds	15							
	Rate	$ [redacted]	$	$	$	$	$	$	
THREE-BED ROOMS	Number of Beds	0							0
	Rate	$	$	$	$	$	$	$	
FOUR-BED ROOMS	Number of Beds	0							0
	Rate	$	$	$	$	$	$	$	
ROOMS WITH MORE THAN FOUR BEDS	Number of Beds	0							0
	Rate	$	$	$	$	$	$	$	
SPECIAL CARE BEDS(ICU,CCU, Intermediate ICU, Burn, etc.	Type	ICU	CCU	IICU	BURN				
	Number of Beds	4							4
	Rate	$ [redacted]	$	$	$	$	$	$	
OTHER BEDS USED-SWING (Isolation, emergencies, halls, etc.)	Type								
	Number of Beds	10							
	Rate	$ [redacted]	$	$	$	$	$	$	
					Total Number of Beds				52

NURSERY RATES	
Normal or Regular	$ [redacted]
Preemie or Intermediate	$ [redacted]
Neonatal, Premature, or ICU Care	$ [redacted]

Return form to:
William G. Nordmark, III
B/C & B/S of Georgia, Inc.
Post Office Box 4445
Atlanta, Georgia 30302

DO NOT WRITE BELOW THIS LINE

AVERAGE SEMI-PRIVATE RATE: $ [redacted]

MOST COMMON SEMI-PRIVATE: (2, 3, 4 BEDS) $ [redacted]

MOST COMMON SEMI-PRIVATE: (2 BEDS) $ [redacted]

AVSP PSYCHIATRIC RATE: $ [redacted]

HIGHEST SEMI-PRIVATE RATE: [redacted]

HIGHEST ICU/CCU RATE: $ [redacted]

PROJECTED ANCILLARY CHANGES IN REVENUE

HOSPITAL NAME: SAINT JOSEPH'S HOSPITAL OF DAHLONEGA

Ancillary Departments	Percentage Increase	Projected Revenues Produced by the Change in the Period Beginning 3/1/18 and Ending 12/31/87
1. Anesthesiology	4 %	$ [redacted]
2. Blood Bank	0 %	$
3. Cardiology (E.K.G.)	0 %	$
4. CAT Scan	0 %	$
5. Emergency Room	%	$
6. Heart Catherization	N/A %	$
7. Labor, Delivery, OB Recovery	0 %	$
8. Laboratory	6 %	$ [redacted]
9. Medical and Surgical Supplies	6 %	$ [redacted]
10. Neurology (E.E.G.)	N/A %	$
11. Nuclear Medicine	0 %	$
12. Occupational Therapy	N/A %	$
13. Operating Room	0 %	$
14. Outpatient Surgery	0 %	$
15. Pharmacy	4 %	[redacted]
16. Physical Therapy	0 %	$
17. Pulmonary Lab	N/A %	$
18. Radiation Therapy	N/A %	$
19. Radiology	0 %	$
20. Recovery Room (Excluding OB)	0 %	$
21. Renal Dialysis	N/A %	$
22. Respiratory Therapy	0 %	$
23. Speech Therapy	0 %	$
24. Other	— %	$

Return form to: William G. Nordmark, III; B/C & B/S of Georgia, Inc.; Post Office Box 4445; Atlanta, Georgia 30302.

AMENDMENT
TO PARTICIPATING AGREEMENT
BETWEEN
BLUE CROSS AND BLUE SHIELD OF GEORGIA, INC.
and
ST. JOSEPH HOSPITAL OF DAHLONEGA, INC. a/k/a
SOUTHERN HEALTH CORPORATION OF DAHLONEGA d/b/a
CHESTATEE REGIONAL HOSPITAL
EFFECTIVE August 19, 2016

WHEREAS, BLUE CROSS BLUE SHIELD OF GEORGIA, INC. ("PLAN") and ST. JOSEPH HOSPITAL OF DAHLONEGA, INC. a/k/a SOUTHERN HEALTH CORPORATION OF DAHLONEGA d/b/a CHESTATEE REGIONAL HOSPITAL ("HOSPITAL") have previously entered into an Agreement (hereinafter referred to as the "Agreement") made and entered into on the 1 day of January, 1987; and

WHEREAS, Section 13.1 of the Agreement states:

No assignment of the rights, duties or obligations of this Agreement shall be made by HOSPITAL. Any attempted assignment in violation of this provision shall be void as to the PLAN.

WHEREAS, St. Joseph Hospital of Dahlonega, Inc. a/k/a/Southern Health Corporation of Dahlonega, Inc. d/b/a Chestatee Regional Hospital ("SHCD") has requested consent to assign the Agreement to Durall Capital Holdings d/b/a Chestatee Regional Hospital ("DCH") which is a newly formed entity that will utilize the hospital assets and conduct the hospital operations previously performed by SHCD and PLAN wishes to consent to the Assignment;

NOW THEREFORE, for and in consideration of the mutual promises and covenants contained in the Amendment, the receipt and sufficiency of which is hereby acknowledged, the parties hereto, intending to be legally bound, agree to modify the Agreement as follows:

PLAN hereby consents to the Assignment of the Agreement by SHCD d/b/a Chestatee Regional Hospital to DCH d/b/a Chestatee Regional Hospital, to DCH d/b/a Chestatee Regional Hospital, and by its execution of this Assignment, DCH d/b/a Chestatee Regional Hospital agrees to be bound by all terms and conditions of the Agreement as "HOSPITAL" therein.

Except for the above, all other terms and conditions of the Agreement remain in full force and effect. Section 13.1 shall apply to any future assignments of the rights, duties or obligations of the Agreement.

IN WITNESS WHEREOF, the parties hereto have executed the Amendment as of the date first written above.

Blue Cross and Blue Shield of Georgia, Inc.

By: Signature

Jeff Fusile
Printed Name

President
Title

8/9/2016
Date

Southern Health Corporation of Dahlonega, Inc. d/b/a Chestatee Regional Hospital

Jeanne Vangelder
By: Signature

Jeanne Vangelder
Printed Name

CEO
Title

9-1-16
Date

Durall Capital Holdings d/b/a Chestatee Regional Hospital

James P. Yarborough
By: Signature

James P. Yarborough
Printed Name

CEO
Title

8/30/16
Date

Amendment to
Hospital Agreement for Participating Provider Program
between
Blue Cross and Blue Shield of Georgia
and

Chestatee Regional Hospital

Effective November 1, 2017 PLAN and HOSPITAL agree that the Hospital Agreement for Participating Provider Program (the "Agreement"), is amended as follows:

The Lab Fee Schedule is added to the agreement as Appendix B.

Except for the above, all other terms and conditions of the Hospital Agreement for Participating Provider Program remain in full force and effect.

To the extent conflict arises between the provisions of the Amendment and those of the Agreement, the provisions of the Amendment shall control.

BLUE CROSS AND BLUE SHIELD OF GEORGIA, INC.

(Signature)

Shalini A.R. Wittstruck
(Printed Name)

Regional Vice President, Georgia Provider Solutions
(Title)

9/26/2017
(Date)

CHESTATEE REGIONAL HOSPITAL

(Signature)

AARON DURALL
(Printed Name)

CEO
(Title)

9/22/2017
(Date)

Chestatee Regional Hospital
Appendix B
PAR Lab Fee Schedule

Lab codes not listed on Lab Fee Schedule will price at $0.00.

CPT	FAC_FEE
36415	$ REDACTED
78267	$
78268	$
80047	$
80048	$
80050	$
80051	$
80053	$
80055	$
80061	$
80069	$
80074	$
80076	$
80081	$
80150	$
80155	$
80156	$
80157	$
80158	$
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80162	$
80163	$
80164	$
80165	$
80168	$
80169	$
80170	$
80171	$
80173	$
80175	$
80176	$
80177	$
80178	$
80180	$
80183	$
80184	$
80185	$
80186	$
80188	$
80190	$

CPT	FAC_FEE
80192	$ REDACTED
80194	$
80195	$
80197	$
80198	$
80199	$
80200	$
80201	$
80202	$
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CPT	FAC_FEE
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81007	$

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81050	$
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81291	$
81292	$
81293	$

CPT	FAC_FEE
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Exhibit B

To Corp

HMO Georgia, Inc.
Hospital Agreement

THIS AGREEMENT is made and entered into this 18 day of May 1998, by and between HMO Georgia, Inc., a Georgia corporation (a wholly owned subsidiary of Blue Cross and Blue Shield of Georgia and a Member of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans) (hereinafter referred to as "HMOGA"), and Chestatee Regional Hospital located at 227 Mtn Drive, Dahlonega, Georgia (hereinafter referred to as "HOSPITAL").

I. RECITALS

1.1 HMOGA is a Georgia corporation, duly licensed by the Insurance Commissioner of the State of Georgia and the Department of Human Resources as an HMO, providing HMO and Point-of-Service Membership Agreements covering the provision of Medical Services in certain markets of Georgia.

1.2 HOSPITAL is a corporation or a hospital authority, duly licensed as a hospital by the State of Georgia Department of Human Resources to provide quality inpatient and outpatient Hospital Services and accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO").

1.3 HOSPITAL and HMOGA desire to enter into a written service agreement to provide and/or arrange for the provision of basic and supplemental Medical Services to certain HMOGA Members in an appropriate manner and to preserve and enhance Member dignity in the most appropriate, efficient and cost effective manner. As designated from time to time by HMOGA, this Agreement may apply to certain enrollees in HMOGA and enrollees of other HMO arrangements with whom HMOGA may be affiliated or for whom HMOGA may administer claims or arrange benefits on behalf of self-insured employers.

1.4 NOW, THEREFORE, in consideration of the promises and the mutual covenants herein stated, it is agreed by and between HMOGA and HOSPITAL as follows:

II. DEFINITIONS

2.1 Affiliate(s) of HMOGA - Those organizations designated from time to time by HMOGA that are associated with HMOGA or for whom HMOGA may administer claims or arrange benefits on behalf of self-insured employers.

2.2 **Agreement** - This contract, including attachments or addenda hereto, that may be issued or amended by HMOGA from time to time.

2.3 **Coinsurance** - The percent of a bill for Covered Services which a Member must pay as set forth in a Membership Agreement.

2.4 **Coordination of Benefits (also referred to as "COB")** - The combining of benefits under a Membership Agreement with duplicate coverage under another health insurance policy such that total benefits paid for Covered Services rendered to a Member do not exceed the amount HMOGA would have paid under the terms of this Agreement had HMOGA been the primary payor.

2.5 **Copayment** - The predetermined amount a Member must pay for Covered Services at the time services are rendered as set forth in a Membership Agreement.

2.6 **Covered Group(s)** - Select group(s) for which HMOGA provides, indemnifies or administers health care benefits under the terms of a Membership Agreement, which may specifically include (without limiting the generality of the foregoing) a group covered or administered by another HMO which is an Affiliate of HMOGA for whom HMOGA provides, indemnifies or administers benefits.

2.7 **Covered Services** - Those services which are reimbursable under the terms of a Membership Agreement and which are Medically Necessary as determined by HMOGA.

2.8 **Emergency** - The treatment for a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in:

(a) Permanently placing a Member's health in jeopardy;

(b) Serious impairment to bodily functions;

(c) Serious and permanent disfunction of any bodily organ or part; or

(d) Other serious medical consequences.

2.9 **Encounter** - Any event or occasion in which any Medical Service is provided to a Member by a Network Provider.

2.10 **Fee Schedule** - A comprehensive listing of fee maximums used to reimburse a Network Provider on a fee-for-service basis for the provision of Covered Services.

2.11 **Guest Member(s)** - Member(s) of an Affiliate of HMOGA temporarily residing in a Service Area. Guest Member(s) will be treated as an HMOGA Member(s) while present in a Service Area.

2.12 **Hospital** - A facility licensed by the State of Georgia Department of Human Resources as a hospital that has been selected by HMOGA for participation in its Provider Network, and that has signed an HMO Georgia, Inc. Hospital Agreement.

2.13 **Hospital Based Physician** - Any physician, with the exception of residents, interns and fellows, who has a contractual relationship with HOSPITAL to provide professional services. These services may be of two types: (1) administrative, managerial, teaching, or quality control activities compensated from or through HOSPITAL which are furnished to HOSPITAL or its general population; or (2) physician services personally rendered to a Member while in HOSPITAL which directly contribute to the diagnosis or treatment of a Member and which ordinarily require performance by a physician, including, an emergency room physician, radiologist, pathologist, and anesthesiologist, and any other physicians contracting with hospitals specified by HMOGA, at any time, or from time to time; provided, however, that this term shall not include Primary Care Physicians or Specialty Care Physicians employed by HOSPITAL who have a separate contractual agreement with HMOGA.

2.14 **Hospital Network** - The group of hospitals designated by and under contract with HMOGA to provide Covered Services to Members.

2.15 **Hospital Services** - Those acute inpatient and outpatient services which a Hospital is licensed by the State of Georgia to provide.

2.16 **Ineligible Services** - Those services which are not Covered Services either because they are not reimbursable under the terms of a Membership Agreement or because they are not Medically Necessary as determined by HMOGA.

2.17 **Medical Director** - A physician appointed by HMOGA to assume overall responsibility for: (1) supervision and implementation of day-to-day administrative policies and procedures related to Network Provider activities; (2) coordination of peer review and Quality Assurance activities; and (3) other Utilization Management activities.

2.18 **Medical Service(s)** - Health care service(s) provided by a Network Provider.

2.19 **Medically Necessary** - Those Covered Services or supplies provided by a Network Provider to identify or treat an illness or injury which, as determined by HMOGA under its Utilization Management Program, are:

a) Consistent with the symptom or diagnosis and treatment of a Member's condition, disease, ailment or injury; and

b) Appropriate with regard to standards of good medical practice; and

c) Generally accepted by the medical community as safe and effective. The treatment must be the appropriate alternative for the situation and it must be required for the condition; and

d) The most appropriate supply or level of service which can be safely provided to a Member. When applied to an inpatient, it further means that a Member's medical symptoms or conditions require that the services or supplies cannot be safely provided to a Member as an outpatient.

2.20 **Member(s)** - Certain person(s) entitled to receive HMOGA benefits as defined in a Membership Agreement.

2.21 **Membership Agreement** - A contract between HMOGA or Affiliates of HMOGA and an employer, group, or individual to provide, indemnify or administer the delivery of health care benefits through a health maintenance organization or point-of-service program.

2.22 **Membership Card** - A currently valid identification card issued by HMOGA entitling a Member to receive Covered Services through a Membership Agreement.

2.23 **Network Provider(s)** - Any physician or group of physicians, or any facility, including, but not limited to, a hospital, clinical laboratory, freestanding ambulatory surgery facility, skilled nursing facility, hospice, home health agency, or any other health care practitioner or provider of Medical Services who has entered into a contractual agreement with HMOGA to provide Covered Services Members.

2.24 **Parties** - HMOGA and the HOSPITAL whose name appears on page one (1) of this Agreement.

2.25 **Physician(s)** - Any physician(s) licensed in the State of Georgia who meets HMOGA's criteria to become a Network Provider and who has signed one of HMO Georgia, Inc.'s Physician Agreements.

2.26 **Primary Care Physician** - A Physician who agrees under a contract with HMOGA to assume primary responsibility for providing or coordinating the overall health care (including referrals to Specialty Care Physicians) of Members who have selected such Physician to do so.

2.27 **Quality Assurance Program (also referred to as "QA Program")** - The program developed or used by HMOGA for the collection and analysis of quantitative and qualitative data which identifies patterns of health care delivery, in order to provide the most beneficial outcome for a Member, given a Member's medical condition before, during and after medical intervention.

2.28 **Service Area(s)** - Those counties specified on Attachment B, as it may be modified or amended by HMOGA by written notice to HOSPITAL at any time or from time to time.

2.29 **Specialty Care Physician** - A Physician, other than a Primary Care Physician, who practices in a recognized medical specialty and who agrees by contract with HMOGA to provide Covered Services to Members.

2.30 **Utilization Management Programs** - The functions described in Article VI below, performed by HMOGA or by any entity or provider selected by HMOGA to review and determine whether Covered Services ordered and/or provided by a Network Provider are Medically Necessary.

III. HOSPITAL SERVICES AND RESPONSIBILITIES

3.1 HOSPITAL shall provide to Members and Guest Members in the relevant Service Area Covered Services in accordance with this Agreement, when such services are ordered by a Physician or other licensed health professional.

3.2 HOSPITAL shall provide Covered Services to Members in the same manner and quality as those services are provided to all non-Member patients of HOSPITAL. HOSPITAL shall not discriminate against any Member based upon the source of payment for services, race, color, sex, age, religion, national origin, handicap, or health status. HOSPITAL shall assure that Covered Services will be provided in a manner intended to preserve human dignity and patient privacy. HOSPITAL shall treat Members with dignity and will not make disparaging remarks to Members.

3.3 HOSPITAL shall assure that services provided are made available and accessible to Members promptly and in a manner that assures continuity of care (including coordinating overall health care and exchanging health records) and agrees to forward all clinical information in a timely manner to other Network Providers engaged in the treatment of Members.

3.4 HOSPITAL agrees to accept HMOGA's payments, under the terms of this Agreement, as payment in full for Covered Services provided to Members. HOSPITAL further agrees to look solely to HMOGA for payment of Covered Services; provided, however, that HOSPITAL may bill Members for: (1) Ineligible Services; (2) applicable deductibles; and (3) coinsurance or copayment amounts as provided in a Member's Membership Agreement. Except as provided in this paragraph, HOSPITAL agrees not to bill Members for the difference between HOSPITAL'S charges and HMOGA reimbursement as set forth in Attachment A.

3.5 In the event that HOSPITAL renders services to a Member which are Ineligible Services, HOSPITAL shall, prior to the provision of such Ineligible Services, inform a Member that: (1) the services to be provided are not reimbursable under a Membership Agreement or the services are not Medically Necessary; (2) HMOGA will not pay for or be liable for such services; and (3) a Member will be financially liable for such services.

3.6 HOSPITAL warrants that it now has, and shall maintain, in good standing: (1) all licenses required by law, (2) JCAHO; (3) certification for participation in the Medicare program; and (4) adequate malpractice and liability insurance or sufficient restricted reserves in lieu of insurance.

3.7 HOSPITAL warrants that it has entered into, and will maintain during the term of this Agreement, both a Participating Hospital Agreement and a PPO Hospital Agreement with Blue Cross and Blue Shield of Georgia.

3.8 HOSPITAL agrees that HMOGA may utilize HOSPITAL's name, services performed, address and phone number in its advertising, publicity and promotional material with current and potential Members and Network Providers. HMOGA agrees that any use of HOSPITAL's name, services, etc. will be in a conservative and ethical manner so as to preserve the dignity of HOSPITAL. Further, HOSPITAL shall display in a prominent location in its admission lobby the symbol of its HMOGA participation in the form provided by HMOGA.

3.9 HOSPITAL shall notify HMOGA immediately, in writing, of:

(a) Any change or notification of possible change in its state licensure, accreditation status by JCAHO or Medicare certification;

(b) Any change in its ownership or business address;

(c) Any legal or governmental action or any other problem or situation which might impair the ability of HOSPITAL to carry out its duties and obligations under this Agreement, including, but not limited to, employee strikes or walkouts, financial insolvency, or damage to the physical plant resulting in any interruption in Medical Services;

(d) Any written complaint, claim, suit or threat of legal action by a Member against HOSPITAL or a member of HOSPITAL's medical staff;

(e) Any action taken by HOSPITAL or its medical staff against a Physician; and

(f) Any change or notification of possible change in professional licensure of staff member or a Physician.

3.10 HOSPITAL agrees to provide to HMOGA ninety (90) days prior written notice of HOSPITAL's intention to add, limit or delete any facility or service identified in Attachment C of this Agreement. If HOSPITAL proposes to limit or delete a facility or service, HMOGA, in its sole discretion, will determine the effect of such limitation or deletion upon HOSPITAL's continued ability to provide the required scope of Covered Services to Members residing within a Service Area. Where HMOGA determines that such limitation or deletion would adversely impact a Member's access to Covered Services within HOSPITAL's Service Area, HMOGA reserves the right to cancel or modify this Agreement subject to the termination requirements contained herein. HMOGA will notify HOSPITAL, in writing, of such cancellation or modification within forty-five (45) days of receipt of notification from HOSPITAL. Such change will become effective on the date of HMOGA's notice to HOSPITAL.

3.11 HOSPITAL agrees to take reasonable steps to ensure that members of its medical staff, health professionals working within HOSPITAL and HOSPITAL employees are at all times appropriately licensed, credentialed and/or certified by the State of Georgia and/or all appropriate professional or other organizations. All employees must also continue to meet all applicable state laws and regulations, all rules of HOSPITAL and its medical staff and all

applicable legal standards of care. HOSPITAL further agrees to cooperate with HMOGA in monitoring the care provided by members of its medical staff, health professionals working within HOSPITAL, and HOSPITAL employees, and to report, immediately, any disciplinary action (suspension, revocation, other form of reduction of privileges, resignation in lieu of disciplinary action sanctions or corrective actions) taken by HOSPITAL's medical staff, board of directors, hospital authority or administration or any agencies of the state or federal government against any member of its medical staff, health professionals working within HOSPITAL or HOSPITAL employees. NOTE: Temporary suspension of a Physician's admitting privileges due to untimely completion of medical records is not required to be reported.

3.12 HOSPITAL agrees to permit HMOGA to conduct audits of HOSPITAL, its facilities, charges, policies and procedures, including, but not limited to, Utilization Management Program audits at any time during HOSPITAL's regular business hours upon 24 hours prior notice. HOSPITAL agrees to permit HMOGA to conduct such other monitoring activities as are deemed necessary by HMOGA to ensure correct payment to HOSPITAL for Covered Services rendered to Members.

3.13 Upon request from HMOGA, HOSPITAL agrees to provide promptly to HMOGA: (1) photostatic copies of its state license; (2) certificates of liability and malpractice insurance (for self-insured hospitals, verification from an independent, third-party as to the adequacy of funded reserves); (3) documentation supporting that HOSPITAL is accredited by JCAHO; (4) documentation that HOSPITAL is certified for participation in the Medicare program; (5) copies of HOSPITAL's most recent audit financial statements; and (6) such other information as HMOGA may require.

3.14 HOSPITAL agrees that HMOGA retains the right to change, revise, modify or alter the form and content of any Membership Agreement without prior notice to or approval by HOSPITAL.

3.15 HOSPITAL shall, and shall cause each of its Hospital Based Physicians to, agree to cooperate and participate with and to be bound by HMOGA's Utilization Management and Quality Assurance Programs and all other policies and procedures established by HMOGA.

3.16 To the extent applicable, Section 202 of Executive Order 11246, as amended by Executive Order 11375, relating to equal employment opportunities, the implementing rules and regulations of the Secretary of Labor, and all contract clauses and requirements which are applicable and set forth therein are incorporated herein by specific reference. In particular, HOSPITAL hereby

certifies that it does not maintain segregated facilities. In making this certification HOSPITAL incorporates each and all of the provisions of the approved form of certification contained in 41 C.F.R. 60-1.8(b) the same as if such provisions were fully set forth herein and signed by HOSPITAL.

To the extent applicable, Sections 503 and 504 of the Rehabilitation Act of 1973 and Title IV of the Vietnam Era Veterans Readjustment Assistance Act of 1974 relating to employment and advancement in the employment of qualified handicapped individuals, disabled veterans and veterans of the Vietnam era, the implementing rules and regulations of the Secretary of Labor, and all contract clauses and requirements which are applicable and set forth therein are incorporated herein by specific reference. To the extent applicable, Sections 1 and 3 of Executive Order 11625 relating to the promotion of minority business enterprises, the implementing rules and regulations of the General Services Administration, and all contract clauses and requirements which are applicable and set forth therein are incorporated herein by specific reference.

3.17 HOSPITAL hereby expressly acknowledges its understanding that this Agreement constitutes a contract between HOSPITAL and HMOGA, that HMOGA is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of Independent Blue Cross and Blue Shield Plans (the "Association") permitting HMOGA to use the Blue Cross and Blue Shield Service Mark(s) in the State of Georgia, and that HMOGA is not contracting as an agent of the Association. HOSPITAL further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than HMOGA and that no person, entity, or organization other than HMOGA shall be held accountable or liable to HOSPITAL for any of HMOGA's obligations to HOSPITAL created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of HMOGA other than those obligations created under other provisions of this Agreement.

IV. HMOGA SERVICES AND RESPONSIBILITIES

4.1 HMOGA agrees to compensate HOSPITAL directly for Covered Services rendered by HOSPITAL to Members, pursuant to the provisions of this Agreement and Attachment A.

4.2 HMOGA shall distribute information to Members detailing Members' responsibilities and procedures, benefit levels, and deductible, copayment and

coinsurance requirements. HMOGA shall provide each Member with a Membership Card.

4.3 HMOGA agrees to perform, or cause to be performed, administrative, accounting, marketing, enrollment, database management, reporting and other functions as it deems necessary for the administration of HMOGA and the performance of this Agreement.

4.4 HMOGA agrees to provide to HOSPITAL periodically information regarding HMOGA's marketing policies, HMOGA's policies and procedures, required billing formats or procedures, deductibles, copayments or coinsurance, if any, to be paid by Members, and such other information as may be reasonably necessary in order to facilitate the provision of Covered Services to Members and payment therefore under this Agreement.

4.5 HMOGA makes no representations or guarantees concerning the number of Members it can or will refer to HOSPITAL for services to be provided under the terms of this Agreement. Upon request of HOSPITAL, HMOGA shall confirm the enrollment status of any individual during HMOGA's regular business hours throughout the term of this Agreement.

4.6 HMOGA agrees to furnish to HOSPITAL HMOGA's best available information regarding Network Providers, Member eligibility for Covered Services and basic coverage. Such information will normally be available only for locally enrolled Members and will be obtained from existing HMOGA records which are available in the ordinary course of business through HMOGA computer terminals. The information may be transmitted to HOSPITAL by electronic means or communicated by telephone. It is understood and agreed by HOSPITAL and HMOGA that circumstances inherent in the record keeping system or circumstances beyond the control of HMOGA may occasionally cause retroactive changes in reported Member eligibility status and coverage. It is understood and agreed by HOSPITAL and HMOGA that final benefit adjudication is subject to and conditioned on the terms and conditions of a Member's Membership Agreement, including, without limitation, eligibility, waiting periods, exclusions, medical waivers or riders, deductibles, coinsurance or other contract limitations, the application of all of which cannot always be determined conclusively prior to claims submission. HOSPITAL understands and agrees that verification of eligibility status and coverage shall not constitute an assurance or guarantee of coverage or payment.

4.7 HMOGA agrees that, in the event its employees or agents erroneously verify an individual's eligibility status or coverage when information available to HMOGA's employees or agents at the time of verification clearly indicates that

such person was not eligible for services or coverage did not exist, HMOGA agrees to make payment to HOSPITAL for Covered Services provided to such person until such time as HMOGA informs HOSPITAL of its error. HMOGA shall have no financial liability to HOSPITAL for any services provided subsequent to notification of HOSPITAL by HMOGA that eligibility or coverage does not exist.

4.8 HMOGA agrees to provide HOSPITAL periodically with a list of all Network Providers.

V. COMPENSATION AND BILLING

5.1 HMOGA shall pay HOSPITAL for the provision of Covered Services rendered to Members in accordance with the provisions of this Agreement and Attachment A. The payment from HMOGA shall be limited to the amounts referred to in this Agreement and Attachment A, less deductible, copayment and coinsurance amounts and amounts received from sources other than HMOGA pursuant to the COB provisions of a Member's Membership Agreement.

5.2 HOSPITAL shall accept such compensation as specified in this Agreement as payment in full for Covered Services. HOSPITAL further agrees that the only charges for which a Member may be liable and may be billed by HOSPITAL are those specified in Section 3.4 above. Under no other circumstances, including, but not limited to, the insolvency of HMOGA, shall HOSPITAL bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against a Member or a person acting on a Member's behalf for Covered Services provided pursuant to this Agreement. HOSPITAL further agrees that: (1) this provision shall survive the termination of this Agreement regardless of the events giving rise to the termination; (2) this provision shall be construed for the benefit of Members; and (3) this provision supersedes any oral or written contrary agreement now existing or hereinafter entered into between HOSPITAL and Members or persons acting on their behalf.

5.3 HOSPITAL agrees that charges for Covered Services rendered to Members shall not exceed HOSPITAL's regular billed charges to persons other than Members for the same services. If multiple charge schedules are maintained by HOSPITAL, the schedule which generates the lowest aggregate charge per case for a service shall be used for Members.

5.4 HOSPITAL further agrees that charges submitted for Covered Services provided to a Member in an outpatient setting will not exceed the charges that would have been submitted had the same service(s) been provided by HOSPITAL in an inpatient setting.

5.5 For all Covered Services provided by HOSPITAL to Members, HOSPITAL agrees to furnish to HMOGA, without charge, on either standard UB-92 claim forms or electronically, all information reasonably required to process Encounters, including, but not limited to, complete and accurate descriptions of health care services performed and charges made, with diagnoses and procedure codes approved by HMOGA (only "CPT IV", "HCPCS", and "ICD-9" are acceptable diagnoses and procedure codes). HOSPITAL shall also inform HMOGA of any other insurance coverage of each Member, which is known to HOSPITAL, including, but not limited to, worker's compensation coverage for job-related injuries or illnesses, and any other information specified by HMOGA as it deems necessary to the performance of this Agreement. HOSPITAL further agrees that in those circumstances where its reasonably appears that a Member is entitled to coverage under another benefit agreement, HOSPITAL will notify HMOGA of such coverage and exert reasonable efforts to obtain information for the Coordination of Benefits.

5.6 Payments made to HOSPITAL by HMOGA are contingent upon the accuracy of diagnostic and other information provided by HOSPITAL to HMOGA. HMOGA shall be permitted to recover from HOSPITAL, and HOSPITAL shall refund to HMOGA, amounts paid by HMOGA because of: (1) payments made in error; (2) Utilization Management Program determinations; (3) services not rendered; (4) provider audits; (5) inaccurate payments, including, but not limited to, payments based upon erroneous or incomplete information provided by HOSPITAL; (6) payment for services later determined by HMOGA to be Ineligible Services (except as provided in Section 4.7 above); and (7) payments made under a COB provision of a Membership Agreement upon which payment has been or should have been made by a primary carrier, (e.g., but not limited to, auto medical, no fault or any liability insurance) or for which benefits are available to a Member under the Worker's Compensation laws of any state or federal jurisdiction. HMOGA shall also have the right to offset any such amounts due HMOGA from future payments due HOSPITAL under any Blue Cross and Blue Shield of Georgia or any HMOGA provider agreement.

5.7 HMOGA shall make adjustments to HOSPITAL for amounts due HOSPITAL because of payment errors made by HMOGA.

5.8 HMOGA shall determine the appropriate amount of deductibles and coinsurance, where applicable, to be paid by a Member on the basis of charges

calculated in accordance with Section 5.3 above. HMOGA shall pay only those amounts, if any, which when added to the deductibles and coinsurance due HOSPITAL from a Member, and amounts received by HOSPITAL from other sources pursuant to the applicable COB rules, total 100% of the lesser of (i) the amount which HOSPITAL would have been paid pursuant to this Agreement had HMOGA had primary responsibility; or (ii) the amount the HOSPITAL has agreed to accept as payment in full from the primary carrier, less the reimbursement set forth in Attachment A of this Agreement.

5.9 HOSPITAL shall bill HMOGA on a monthly basis in a manner and on forms prescribed by HMOGA (currently UB-92). Health Care Financing Administration's Common Procedure Coding System (HCPCS) Coding is required on all HOSPITAL outpatient claims. HOSPITAL shall furnish, on request, all information reasonably required by HMOGA, including, but not limited to, the detailed bill, medical record, and current charge master, to verify and substantiate the provision of and the charges for Covered Services. HMOGA reserves the right to review any and all statements, bills, claims or invoices submitted by HOSPITAL to HMOGA for reimbursement.

5.10 Unless otherwise agreed, HOSPITAL shall use its best efforts to submit all bills for Covered Services provided to Members within thirty (30) days after the services are rendered, but in no instance may the bill be submitted later than ninety (90) days from the date services are rendered.

5.11 HOSPITAL shall submit only one claim per admission for Covered Services provided to Members and only after all charges and credits have been recorded on the claim. Such claims must include charges from any other hospital or facility for specific care or treatment when transported thereto from HOSPITAL because such services were not available in HOSPITAL . The entire claim must be billed and processed at one time; therefore, HOSPITAL agrees not to bill portions of a claim whether on an interim cycle billing basis or split over the end of a calendar or fiscal year. **(EXCEPTION: HOSPITAL may submit an interim bill for inpatient services provided to a Member for every thirty (30) days of continuous inpatient hospitalization during the same admission).**

5.12 HOSPITAL agrees that charges for services provided by Hospital Based Physicians will be separated from the HOSPITAL claim and filed on the HCFA-1500 and that reimbursement for such services will be paid to HOSPITAL based on an HMOGA Fee Schedule. Any charges filed that exceed the charges included in the Fee Schedule may not be billed to a Member.

VI. UTILIZATION MANAGEMENT

6.1 HOSPITAL agrees to cooperate in the administration and implementation and to be bound by, the procedures and determinations of the Utilization Management Programs established by HMOGA, as described in this Article VI.

6.2 Utilization Management Programs conducted by HMOGA shall determine whether Covered Services are Medically Necessary. Reviews and determinations shall include, but are not limited to, lengths of stay and the appropriateness of referrals to and payment for inpatient hospitalization, outpatient care or diagnostic services. Utilization Management shall also include review as to whether services are Ineligible Services for reasons such as preexisting conditions, cosmetic procedures, or custodial care, according to the terms of a Member's Membership Agreement.

6.3 The determination of whether a Covered Service is Medically Necessary shall be made according to the protocols and procedures used in the Utilization Management Program and is not to be determined by the mere fact that a Physician has ordered a service or supply. Payment shall not be rendered for a particular claim unless the procedures described below are followed (as outlined in HMOGA's Utilization Management Manual) in addition to any other procedures, or modification of existing procedures, that may be specified by HMOGA at any time or from time to time following notification by HMOGA to HOSPITAL:

(a) Pre-admission Certification - To determine the medical necessity of an inpatient admission or authorization to perform outpatient surgery, outpatient diagnostic procedures or treatment, or any related inpatient or outpatient service.

(b) Admission Review - To determine whether an unscheduled inpatient admission or an admission not subject to Pre-admission Certification is Medically Necessary. Maternity admissions or Emergency admissions are excluded from Pre-admission Certification; provided, however, that HMOGA shall be notified of such admission by HOSPITAL on the next working day following the day of admission.

(c) Concurrent Review - To determine whether a continued inpatient hospital stay is Medically Necessary.

(d) Outpatient Review - To determine the appropriateness of selected outpatient diagnostic and treatment procedures as identified by HMOGA.

(e) Discharge Planning - To determine the continuation of appropriate health care services for a Member's treatment and/or convalescence subsequent to discharge from a hospital.

(f) Case Management - HOSPITAL shall provide case management services to selected Members as determined by HMOGA and shall work cooperatively with HMOGA, a Member and/or a Member's family to identify appropriate alternative treatment settings during Concurrent Review.

(g) Referral Management - HOSPITAL shall cooperate with and follow HMOGA's referral management policies and procedures.

HOSPITAL expressly understands and agrees that failure to follow any procedures specified in the Utilization Management Programs or any modifications to the Utilization Management Programs specified by HMOGA can result in limitation of payments, and HOSPITAL expressly agrees not to bill any Member for any unpaid charges that result from failure by HOSPITAL to comply with the procedures of the Utilization Management Programs or from an adverse determination that a service is not Medically Necessary. Notwithstanding the provisions of this Section, HMOGA agrees to exercise reasonable efforts to avoid retrospective denial of claims for services to the extent possible within the confines of the Utilization Management Program procedures.

6.4 HMOGA shall notify HOSPITAL promptly, either by written notice, telephone or other electronic communication, when HMOGA determines through the Utilization Management Programs: (1) that a service is not Medically Necessary; (2) that it will not accept financial responsibility for initial or continued inpatient hospitalization, outpatient diagnostic or treatment procedures; or (3) when HMOGA determines that a less restrictive or more appropriate setting is available for treatment of the Member in question.

6.5 Except as provided in this Section, HMOGA's decision as to whether a service is Medically Necessary is final for an individual claim. HOSPITAL agrees that HMOGA may conduct a medical review of all cases prior to payment. Should HOSPITAL disagree with HMOGA's initial determination not to accept financial liability for initial or continued inpatient hospitalization, outpatient diagnostic or treatment procedures, or that a more appropriate setting is available, HOSPITAL may appeal HMOGA's determination to the Medical Director or his/her designee. Such an appeal must be made no later than the first working day following notification by HMOGA of its determination in regard to a claim. The decision of the Medical Director, or his/her designee, shall be binding on HOSPITAL, HMOGA and a Member.

6.6 HOSPITAL expressly agrees that it will not bill or attempt to collect fees or charges either from HMOGA or a Member for the cost to HOSPITAL arising out of its participation in HMOGA's Utilization Management Programs or such other Utilization Management Programs as required by an Affiliate of HMOGA.

6.7 HOSPITAL agrees to submit to HMOGA its own utilization management program, if any, and/or any changes or modifications made to such program, upon request by HMOGA.

VII. QUALITY ASSURANCE PROGRAM

7.1 HOSPITAL also agrees to cooperate and participate with HMOGA and other Network Providers in the development, implementation and ongoing operation of a Quality Assurance (hereinafter referred to as "QA") Program and to satisfy any related requirements. Related requirements include, but are not limited to, the supply and collection of data necessary to conduct profiling of Network Providers in a manner and format prescribed by HMOGA.

7.2 HOSPITAL and HMOGA mutually agree that the purpose of the QA Program shall be the collection and analysis of quantitative and qualitative data which identify patterns of health care delivery providing the most beneficial and cost-effective outcome for a Member, given a Member's medical condition before, during and after medical intervention.

7.3 HOSPITAL agrees to provide to HMOGA summary QA Program data in a manner and format prescribed by HMOGA.

7.4 HMOGA agrees to provide to HOSPITAL comparative QA Program reports in a manner and format prescribed by HMOGA.

VIII. RECORDS MAINTENANCE, AVAILABILITY, INSPECTION AND AUDIT

8.1 HOSPITAL shall prepare and maintain all appropriate medical, financial and administrative records on Members receiving Covered Services at HOSPITAL. The records shall be prepared and maintained in accordance with prudent record-keeping procedures and as required by law.

8.2 HOSPITAL and HMOGA further agree to treat any and all records required to be prepared or maintained by this Agreement in the same manner as they do their own confidential information and agree to take all reasonable precautions to prevent the unauthorized disclosure of such records to third parties.

8.3 Ownership and access to HOSPITAL's records of Members shall be controlled by applicable federal, state and local laws and this Agreement. HOSPITAL shall maintain the confidentiality of information contained in a Member's medical records and will only release such information that is permitted by applicable laws and that is: (1) necessary to other providers treating a Member; (2) necessary for HOSPITAL medical review committees; or (3) consented to by a Member. This Section will not be construed to prevent

HOSPITAL from releasing information which it has taken from such records to organizations or individuals taking part in research, experimental, educational or similar programs, if no identification of a Member is made in the released information.

8.4 Notwithstanding any other provision of this Agreement, including termination of this Agreement for any reason under Article XII, HOSPITAL shall retain, and HMOGA shall have access to, a Member's records for a period of at least six (6) years after the last Encounter for adults, and for at least six (6) years after a minor reaches the age of majority. This information may be retained as originals, on microfilms, or in other usable forms and shall afford a basis for a complete audit of professional information about services rendered to Members.

8.5 Notwithstanding any other provision of this Agreement, HOSPITAL agrees to allow HMOGA to inspect, audit and duplicate any and all information, including, but not limited to, billing, payment, Utilization Management, and medical records maintained by HOSPITAL on Members pursuant to this Agreement, with the understanding that each Member has waived any provision of law forbidding such disclosure as a condition of enrollment as a Member. With such waiver, medical records of Members shall also be made available to other Network Providers participating in a Member's medical care as well as to HMOGA to make determinations regarding quality of care, Utilization Management Programs, peer review, grievance review or for other purposes. Such inspection, audit and duplication shall be allowed upon reasonable notice to HOSPITAL by HMOGA during HOSPITAL's normal business hours, and duplication of such data and records shall be provided, without cost, to HMOGA or Members.

IX. LIABILITY, INDEMNITY AND INSURANCE

9.1 Neither HMOGA nor HOSPITAL, nor any of their respective agents or employees, shall be liable to third parties for any act or omission of either HOSPITAL or HMOGA.

9.2 HOSPITAL agrees to indemnify and hold HMOGA harmless from any and all liability, loss, damages, fines, demands, suits, actions, claims or expenses of any kind, including costs and attorney's fees, which result from any action involving alleged medical liability by HOSPITAL, its agents or employees, or members of its medical staff, or which results from negligent or willful acts or omissions by HOSPITAL, its agents or employees or members of its medical staff, regarding the performance of the duties and obligations of HOSPITAL under the terms of this Agreement, including, but not limited to, the duty to maintain the legal standard of care applicable to HOSPITAL. HMOGA agrees to indemnify and hold HOSPITAL harmless for any and all liability, loss,

damages, fines, demands, suits, action, claims or expenses, including costs and attorney's fees, which result from negligent acts or willful acts or omissions by HMOGA, its agents or employees, regarding the performance of the duties and obligations of HMOGA under the terms of this Agreement.

9.3 HOSPITAL shall promptly notify HMOGA of the initiation of legal action against HOSPITAL or any of its agents, employees or members of its medical staff, by a Member. HMOGA shall promptly notify HOSPITAL of the initiation of legal action against HMOGA by a Member, concerning or relating to the services rendered by HOSPITAL.

9.4 Should an employer, group or individual for whom HMOGA or an Affiliate of HMOGA provides, indemnifies or administers health care benefits, enter bankruptcy proceedings and be unable to reimburse HMOGA-established premiums, claims expenses, administrative or other fees, HMOGA's obligations under any Membership Agreement relating to such person shall cease immediately, and HMOGA shall have no obligation to HOSPITAL under this Agreement. HOSPITAL agrees to indemnify and hold HMOGA and Members harmless from any and all liability, loss, damage, claim or expense of any kind, including costs and attorney's fees, which result from any such bankruptcy proceedings.

9.5 HOSPITAL shall procure and maintain, at its sole cost and expense, comprehensive general, professional liability insurance and such other insurance as shall be necessary to insure HOSPITAL and its employees against any and all claims for damages arising from the duties and obligations of HOSPITAL under the terms of this Agreement. HOSPITAL shall maintain other insurance coverage as requested by HMOGA.

9.6 HOSPITAL agrees to provide to HMOGA, upon request, copies of all certificates of insurance required by this Agreement and shall provide evidence of HOSPITAL's ability to meet any other requirement of this Article. In the event that HOSPITAL reserves funds to meet the insurance requirements of this Agreement, either in whole or in part, HOSPITAL agrees to provide HMOGA with a statement from its independent auditor, consultant or other independent, qualified expert attesting to the adequacy of such reserves.

X. MARKETING, ADVERTISING AND PUBLICITY

10.1 HMOGA shall market, in its discretion, the availability of HMOGA products to eligible groups and individuals, and shall encourage Members to use the services of all Network Providers and HOSPITAL specifically, when appropriate.

10.2 Except as provided in other provisions of this Agreement, HMOGA and HOSPITAL each reserves the right and control of the use of its name, symbols, trademarks and service marks, owned by or licensed to it, presently existing or later established. In addition, except as provided in other provisions of this Agreement, neither HMOGA nor HOSPITAL shall use the other's name, symbols, trademarks or service marks in advertising or promotional material or otherwise without the prior written consent of the other and shall cease any such use immediately upon written notice directing that such use be stopped or upon termination of this Agreement, whichever is sooner.

XI. DISPUTE RESOLUTION

11.1 HMOGA and HOSPITAL agree to meet and confer in good faith to resolve any problems or disputes that may arise under this Agreement.

11.2 In the event that any problem or dispute concerning the terms of this Agreement or arising out of this Agreement, other than a Utilization Management Program decision provided for in Article VI, is not satisfactorily resolved, HMOGA and HOSPITAL agree to submit the dispute to the Board of Directors of HMOGA for consideration and possible resolution.

11.3 HOSPITAL and HMOGA shall cooperate in all grievance proceedings of Members as established by HMOGA and approved by the Georgia Insurance Department.

11.4 HOSPITAL shall maintain a mechanism for processing and logging Member concerns and provide HMOGA the results.

XII. TERM AND TERMINATION

12.1 When executed by both Parties, this Agreement shall become effective as of the date noted on page one (1) and shall continue in effect for two (2) years unless terminated by either HOSPITAL or HMOGA as provided in this Article XII. Following completion of the initial term, this Agreement shall be renewed

automatically for additional one (1) year terms, unless terminated by either HOSPITAL or HMOGA as provided in this Article XII; provided, however, that the compensation arrangements set forth in Attachment A shall be effective only for the period specified therein, and for such additional period of time until the Parties mutually agree, in writing, to different compensation arrangements. HMOGA and HOSPITAL shall review annually the compensation arrangements set forth in Attachment A.

12.2 Notwithstanding any other provision of this Agreement, either HOSPITAL or HMOGA may terminate this Agreement at any time, with or without cause, by giving at least ninety (90) days prior written notice. The effective date of such termination shall be the first day of the month occurring at least ninety (90) days after the date of notice of termination.

12.3 HMOGA may suspend or terminate this Agreement immediately with cause. Suspension or termination with cause may result from, but is not limited to, the following actions or omissions by HOSPITAL: failure to continue to meet HMOGA's credentialing criteria, misrepresentation of information on the application, submission of charges for services not rendered, falsely billing for services or repeatedly mis-identifying actual services performed, inappropriate conduct toward patients, quality of care issues, and interference with other programs of HMOGA or its affiliates.

12.4 Either HOSPITAL or HMOGA may terminate this Agreement in the event of a material breach of this Agreement by either HOSPITAL or HMOGA upon thirty (30) days prior written notice. Such notice shall include a description of the specific reason(s) for termination. This Agreement shall terminate automatically at the end of such thirty (30) day period if the breaching HOSPITAL or HMOGA has not cured the breach within such period and demonstrated evidence of such cure to the satisfaction of the non-breaching HOSPITAL or HMOGA. Nothing contained in this Agreement shall be construed to limit either HOSPITAL's or HMOGA's lawful remedies in the event of a material breach of this Agreement.

12.5 This Agreement shall terminate automatically, without notice, upon the suspension or revocation of HOSPITAL's license to operate, loss of accreditation by JCAHO, loss of certification for participation in the Medicare program or change in the ownership of HOSPITAL.

12.6 Termination of this Agreement for any reason shall not, except for termination under Section 12.5, affect the status of any other arrangement the HOSPITAL has with HMOGA's parent corporation, Blue Cross and Blue Shield of Georgia. However, HOSPITAL agrees not to terminate any other agreement it has with Blue Cross and Blue Shield of Georgia prior to the termination of this Agreement.

12.7 If this Agreement is terminated pursuant to any provision, other than Section 12.5, HOSPITAL shall continue to provide Covered Services under the terms of this Agreement to Members who are hospital inpatients on the date of termination until those Members are discharged or are transferred by HMOGA to another Network Provider.

12.8 Termination of this Agreement shall have no effect upon the rights and obligations of the Parties arising out of any transactions occurring prior to the effective date of termination. In the event of termination, HOSPITAL will cooperate with HMOGA in the orderly transfer of a Member's care, including a Member's medical records, to other Network Providers. HOSPITAL and HMOGA will cooperate to resolve promptly any outstanding financial, administrative or patient care issues upon termination or expiration of this Agreement.

12.9 During the term of this Agreement, and following the termination or expiration of this Agreement, HOSPITAL agrees to refrain from any action that interferes with the relationship between HMOGA and its existing or prospective Members or Network Providers.

12.10 It is the responsibility of HMOGA to notify Members of the termination of this Agreement.

XIII. UNFORESEEN CIRCUMSTANCES

13.1 In the event that the operations of HOSPITAL's facilities are substantially interrupted by acts of war, fire, insurrection, labor disputes, riots, earthquakes, tornados, other acts of nature, or power or other utility failures, HOSPITAL shall be relieved of its obligations only as to those affected operations and only as to those affected portions of this Agreement for the duration of such interruption.

13.2 Notwithstanding the provisions of Section 13.1, in the event that the provision of Covered Services by HOSPITAL is substantially interrupted pursuant to an event described in Section 13.1, HOSPITAL shall have the right to terminate this Agreement upon thirty (30) days prior written notice to HMOGA. Such notice of termination may be withdrawn if HOSPITAL, in its sole judgment, determines during the said thirty (30) day period that Covered Services can be performed in spite of the event or because the interruption has ended.

13.3 In the event that the provision of Covered Services by HOSPITAL to Members is interrupted for any reason set forth in Section 13.1, HMOGA's obligation under this Agreement to compensate HOSPITAL for Covered Services shall cease for the period of the interruption.

XIV. GENERAL PROVISIONS

14.1 HOSPITAL understands and agrees that, as designated from time to time by HMOGA, this Agreement may apply to certain enrollees in HMOGA and enrollees of other HMO arrangements with whom HMOGA may be affiliated or for whom HMOGA may administer claims or arrange benefits on behalf of self-insured employees.

14.2 No assignment of the rights, duties or obligations of this Agreement shall be made by HOSPITAL.

14.3 Waiver of a breach of any provision of this Agreement shall not be deemed a waiver of any other breach of the same or a different provision.

14.4 In the event any provision of this Agreement is rendered invalid or unenforceable by any federal, state or local law, or by any regulation duly promulgated by officers of the United States or of the State of Georgia acting in accordance with the law, or declared null and void by any court of competent jurisdiction, the remainder of the provisions of this Agreement shall remain in full force and effect.

14.5 In the event that a provision of this Agreement is rendered invalid or unenforceable or is declared null and void as provided in Section 14.4 and its removal has the effect of materially altering the obligations of either HOSPITAL or HMOGA in such manner as in the judgment of the entity affected: (1) will preclude the provision of Covered Services pursuant to the terms of this Agreement; (2) will cause serious financial hardship to the entity affected; or (3) will cause such entity to act in violation of its corporate articles or bylaws, the entity so affected shall have the right to terminate this Agreement upon thirty (30) days prior written notice to the other entity.

14.6 HMOGA and HOSPITAL are independent entities. Nothing in this Agreement shall be construed or be deemed to create a relationship of employer and employee or principal and agent, or any relationship other than that of independent parties contracting with each other solely for the purpose of carrying out the provisions of the Agreement.

14.7 HOSPITAL agrees to cooperate with HMOGA in programs relating to the Coordination of Benefits and other third party claims for Covered Services provided to Members and to execute any further documents that may reasonably be required or appropriate for this purpose.

14.8 HMOGA may amend this Agreement at any time or from time to time. Except as otherwise provided in this Agreement, an amendment shall automatically become part of this Agreement sixty (60) days after written notice of the amendment has been mailed to HOSPITAL.

14.9 HOSPITAL agrees that when examinations are conducted pursuant to the Official Code of Georgia Annotated Section 33-21-17, HOSPITAL and HMOGA will produce and make freely accessible to the Georgia Insurance Commissioner and the Georgia Commissioner of Human Resources all accounts, records, documents and files in their possession or control relating to the subject of the examination. HOSPITAL and HMOGA officers, employees and representatives will also produce and make freely accessible such material and will facilitate the examination and aid the examiners as far as is within their powers.

14.10 The headings of the Articles contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

14.11 Attachments and Appendices hereto are fully incorporated into and made a part of this Agreement by reference herein.

14.12 Due to the competitive nature of the health care market and the selection of Hospitals to participate as Network Providers, HMOGA and HOSPITAL agree that the terms of this Agreement and all records, documents, data, figures and other information required to be prepared or maintained by this Agreement shall be kept strictly confidential, unless otherwise provided in this Agreement or by federal, state or local laws. Such information includes, but is not limited to, the terms of this Agreement, reimbursement methodologies, particular reimbursement amounts, HMOGA enrollment data, and Utilization Management Programs and figures. Disclosure of such information by HOSPITAL, or its agents, employees, or representatives may result in automatic termination of this Agreement. HMOGA may disclose the terms of this Agreement to Affiliates of HMOGA which are owned, in whole or in part, by Blue Cross and Blue Shield of Georgia directly, or indirectly through one of its intermediaries or subsidiaries. HMOGA may also disclose the terms of this Agreement to non-parties for the purpose of: (1) soliciting new business to be served by Network Providers; (2) administering claims incurred by accounts which are served by Network Providers, including administration on the NASCO system; or (3) facilitating a claims audit. HMOGA and HOSPITAL, their agents and employees, may disclose to non-parties that HOSPITAL is a Network Provider. HMOGA and HOSPITAL may also disclose the specified terms of this Agreement to non-parties with the prior written approval of either HOSPITAL or HMOGA.

14.13 This Agreement is entered into by HOSPITAL and HMOGA with the express understanding and agreement that this Agreement shall not be construed nor considered to be a contract between HOSPITAL and other Hospitals who are parties to similar contracts, nor shall it constitute an agreement that HOSPITAL may act as agent for any other hospital that becomes a party to a similar contract or impose any liability upon any other Hospital by reason of any act

or acts of omission or commission on its part, nor shall HOSPITAL incur any liability by reason of any act or acts of omission or commission of any other Hospital.

14.14 This Agreement shall not be construed to be an exclusive agreement between HMOGA and HOSPITAL. Nothing in this Agreement shall be construed to restrict HMOGA or HOSPITAL from entering into other contracts or agreements to provide health care services to other health care delivery plans, patients or employer groups.

14.15 This Agreement shall be construed and enforced in accordance with the laws of the State of Georgia.

14.16 This Agreement shall not be deemed to be an agreement requiring Physicians or any other Network Providers to refer any Members to HOSPITAL.

14.17 This Agreement replaces and supersedes all prior agreements between the Parties for this product line.

14.18 Any notices required to be given pursuant to the terms and provisions of this Agreement shall be in writing and shall be either hand-delivered or sent by certified mail, return receipt requested, postage prepaid, to HMOGA at:

Blue Cross and Blue Shield of Georgia
Attention: Corporate Provider Services
3350 Peachtree Road. N.E.
Atlanta, GA. 30326

and to HOSPITAL at the address shown on the application form submitted by HOSPITAL.

FOR HMOGA:

(Signature)

MARK CLAYTON
(Name Printed)

VP
(Title)

5/12/98
(Date)

FOR HOSPITAL:

CHESTATEE REGIONAL HOSPITAL
(Name of Hospital)

(Signature)

GAYLE BRADLEY
(Name Printed)

DIRECTOR, MANAGED CARE
(Title)

5/13/98
(Date)

BLUECHOICE HEALTHCARE PLAN/OPTION PROPOSAL
CHESTATEE REGIONAL HOSPITAL
REIMBURSEMENT RATES

1. Name of Facility: Chestatee Regional Hospital

2. Reimbursement Period: Reimbursement rates below are effective for HMO/POS claims incurred from June 1, 1998 through May 31, 1999.

3. Inpatient Per Diem Payment Rates: Reimbursement for approved eligible inpatient services will be at the following rates:

Medical	REDACTED
Surgical	
OB Normal	
OB -Section	
Boarder Baby	
ICU/CCU/NICU	

4. Outpatient/Other Payment Rate (including but not limited to Emergency Room, Implantables, Pharmaceuticals) REDACTED

5. Outpatient Surgery

ASC 1	REDACTED
ASC 2	
ASC 3	
ASC 4	
ASC 5	
ASC 6	
ASC 7	
ASC 8	

6. Stop Loss: REDACTED REDACTED

FOR HMO GEORGIA, INC.

FOR HOSPTIAL

BY: Signature

MARK CLAYTON
Name Printed

VP
Title

5/18/98
Date

CHESTATEE REGIONAL HOSPITAL
Name of Hospital

BY: Signature

GAYLE BRADLEY
Name Printed

Director, Managed Care
Title

5/14/98
Date

AMENDMENT TO
HOSPITAL AGREEMENT FOR PREFERRED PROVIDER ORGANIZATION
Between
BLUE CROSS AND BLUE SHIELD OF GEORGIA
And
Chestatee Regional

Effective, March 1, 2006

Blue Cross and Blue Shield of Georgia (BCBSGa) and Chestatee Regional Hospital (HOSPITAL), parties to a BCBSGa Hospital Agreement (Agreement) dated May 18, 1998 agree as follows:

WHEREAS, BCBSGa and HOSPITAL are parties to a PPO Hospital Agreement which includes provisions relating to the rendering of outpatient radiology services by HOSPITAL, and

WHEREAS, certain claims (the "Disputed Claims" as defined below) have been disputed between BCBSGa and HOSPITAL, and

WHEREAS, the parties desire to settle the "Disputed Claims" and enter into releases in connection therewith pursuant to this Amendment.

NOW THEREFORE, the existing Attachment A, Hospital Reimbursement Rates of Agreement shall be amended as follows:

For the period of March 1, 2006 through April 30, 2006 reimbursement for approved inpatient services will be at the following rates:

Inpatient Services	Per Diem
Medical Surgical ICU/CCU Boarder Baby	REDACTED

Effective May 1, 2006 reimbursement for approved inpatient services will be at the following rates or as updated in accordance with Appendix A, Section 2.:

Inpatient Services	Per Diem
Medical Surgical ICU/CCU Boarder Baby	REDACTED

The Parties agree that these increased reimbursement rates for the period of March 1, 2006 through April 30, 2006, shall be in full settlement for all outpatient radiology services for the period of February 1, 2005 through February 28, 2006.

Performance of the obligations stated above shall release BCBSGa from further obligations with respect to the outpatient radiology claims incurred from February 1, 2005 through February 28, 2006.

To the extent conflict arises between the provisions of the Amendment and those of the Agreement, the provisions of the Amendment shall control.

Except for the above, all other terms and conditions of the Agreement remain in full force and effect.

IN WITNESS WHEREOF, the parties hereto have executed the Amendment as of the date shown on the first page hereof.

FOR BLUE CROSS BLUE SHIELD OF GEORGIA, INC.

(Signature)

Merri S. Rivers
(Printed Name)

Vice President, Network Management
(Title)

2/16/06
(Date)

FOR HOSPITAL

(Signature)

Rob Followell
(Printed Name)

CEO
(Title)

2/6/06
(Date)

AMENDMENT
TO HOSPITAL AGREEMENT
BETWEEN
HMO GEORGIA, INC (a wholly owned subsidiary of BLUE CROSS BLUE SHIELD HEALTHCARE PLAN OF GEORGIA, INC.)
and
CHESTATEE REGIONAL HOSPITAL

EFFECTIVE August 19, 2016

WHEREAS, HMO GEORGIA, INC a wholly owned subsidiary of BLUE CROSS BLUE SHIELD HEALTHCARE PLAN OF GEORGIA, INC. ("HMOGA") and SOUTHERN HEALTH CORPORATION OF DAHLONEGA d/b/a CHESTATEE REGIONAL HOSPITAL ("Hospital") have previously entered into an Agreement (hereinafter referred to as the "Agreement") made and entered into on the 18th day of May , 1998; and

WHEREAS, Section 14.2 of the Agreement states:

No assignment of the rights, duties or obligations of this Agreement shall be made by HOSPITAL.

WHEREAS, Southern Health Corporation of Dahlonega, Inc. d/b/a Chestatee Regional Hospital ("SHCD") has requested consent to assign the Agreement to Durall Capital Holdings d/b/a Chestatee Regional Hospital ("DCH ") which is a newly formed entity that will utilize the hospital assets and conduct the hospital operations previously performed by SHCD and HMOGA wishes to consent to the Assignment;

NOW THEREFORE, for and in consideration of the mutual promises and covenants contained in the Amendment, the receipt and sufficiency of which is hereby acknowledged, the parties hereto, intending to be legally bound, agree to modify the Agreement as follows:

HMOGA hereby consents to the Assignment of the Agreement by SHCD d/b/a Chestatee Regional Hospital to DCH d/b/a Chestatee Regional Hospital, and by its execution of this Assignment, DCH d/b/a Chestatee Regional Hospital agrees to be bound by all terms and conditions of the Agreement as "Hospital" therein.

Except for the above, all other terms and conditions of the Agreement remain in full force and effect. Section 14.1 shall apply to any future assignments of the rights, duties or obligations of the Agreement.

IN WITNESS WHEREOF, the parties hereto have executed the Amendment as of the date first written above.

Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.

By: Signature

Jeff Fusile
Printed Name

President
Title

8/9/2016
Date

Southern Health Corporation of Dahlonega, Inc. d/b/a Chestatee Regional Hospital

By: Signature

Jeanne Vangdahr
Printed Name

CEO
Title

9-1-16
Date

Durall Capital Holdings d/b/a Chestatee Regional Hospital

By: Signature

James P. Yarborough
Printed Name

CEO
Title

8/30/16
Date

AMENDMENT TO HOSPITAL AGREEMENT
Between
BLUE CROSS BLUE SHIELD HEALTHCARE PLAN OF GEORGIA, INC.
And
CHESTATEE REGIONAL HOSPITAL

Effective November 1, 2017

Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. (BCBSHP) and Chestatee Regional Hospital (HOSPITAL), parties to and BCBSHP Hospital Agreement (Agreement), is amended as follows:

The Lab Fee Schedule is added to the agreement as Attachment B. Stat Lab restrictions will apply.

Except for the above, all other terms and conditions of the Agreement remain in full force and effect.

To the extent conflict arises between the provisions of the Amendment and those of the Agreement, the provisions of the Amendment shall control.

IN WITNESS WHEREOF, the parties hereto have executed the Amendment as of the date shown on the first page hereof.

BLUE CROSS BLUE SHIELD HEALTHCARE PLAN OF GEORGIA, INC.

(Signature)

Shalini A. R. Wittstruck
(Printed Name)

Regional Vice President, Georgia Provider Solutions
(Title)

9/26/2017
(Date)

CHESTATEE REGIONAL HOSPITAL

(Signature)

AARON DURALL
(Printed Name)

CEO
(Title)

9/22/2017
(Date)

Chestatee Regional Hospital
Attachment B
HMO Lab Fee Schedule

Stat Lab restrictions apply. Lab codes not listed on Lab Fee Schedule will price at $0.00.

CPT	FAC FEE
80047	$ REDACTED
80048	$
80051	$
80069	$
80162	$
80170	$
80198	$
80200	$
80202	$
81000	$
81001	$
81002	$
81003	$
81005	$
81015	$
81025	$
82140	$
82150	$
82247	$
82248	$
82270	$
82272	$
82274	$
82565	$
82657	$
82670	$
82731	$
82803	$
82805	$
82945	$
82947	$
82948	$
83002	$
83014	$
83036	$
83518	$
83661	$
83861	$
83986	$
84081	$
84132	$
84144	$

CPT	FAC FEE
84157	$ REDACTED
84484	$
84520	$
84703	$
85002	$
85004	$
85007	$
85008	$
85009	$
85013	$
85014	$
85018	$
85025	$
85027	$
85041	$
85044	$
85045	$
85048	$
85097	$
85379	$
85460	$
85461	$
85576	$
85610	$
85651	$
85652	$
85730	$
86077	$
86140	$
86308	$
86403	$
86406	$
86580	$
86756	$
86759	$
86850	$
86880	$
86885	$
86900	$
86901	$
86920	$
86921	$

CPT	FAC FEE
86922	$ REDACTED
86923	$
87045	$
87110	$
87164	$
87205	$
87210	$
87220	$
87280	$
87400	$
87803	$
87804	$
87807	$
87809	$
87880	$
87905	$
88172	$
88173	$
88177	$
88319	$
88738	$
89050	$
89051	$
89060	$
89230	$
89250	$
89300	$
89310	$
89320	$
89321	$
89322	$
89325	$
89329	$
89330	$
89331	$
89253	$
89254	$
89255	$
89258	$
89259	$
89260	$
89272	$

CPT	FAC FEE
89280	$ REDACTED
89281	$
89290	$
89291	$
89335	$
89342	$
89343	$
89346	$
89352	$
89356	$

Exhibit C

TO CORP.

HOSPITAL AGREEMENT
FOR
PREFERRED PROVIDER PROGRAM
BETWEEN
BLUE CROSS AND BLUE SHIELD OF GEORGIA
AND

THIS AGREEMENT made this 18 day of MAY, 19 98 by and between Blue Cross and Blue Shield of Georgia, Inc. (hereinafter referred to as the "PLAN"), a Georgia for-profit corporation, and CHESTATEE REGIONAL HOSPITAL located at 227 MOUNTAIN DRIVE, DAHLONEGA, Georgia (hereinafter referred to as "HOSPITAL").

WHEREAS, The PLAN is a Georgia for-profit health care corporation, duly licensed by the Insurance Commissioner of the State of Georgia providing health care plans covering the provision of health care services.

WHEREAS, HOSPITAL is a corporation or a hospital authority, duly licensed by the State Department of Human Resources of the State of Georgia to provide quality inpatient and outpatient Hospital services;

WHEREAS, HOSPITAL provides hospital services which meet or exceed all legal standards of care and that comply: (a) with all applicable federal, State and local laws, and (b) standards or conditions of participation of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Medicare Program, respectively, and (c) standards of the Plan.

WHEREAS, PLAN and HOSPITAL desire to participate in a program for health care coverage whereby an enrollee of the PLAN's preferred provider organization ("PPO") product, enrollees of other PPOs with which PLAN is or may become affiliated, and enrollees of other PPO arrangements which PLAN may administer on behalf of self-insured employers are offered financial incentives to obtain health care services from institutional providers which have entered into a PPO Hospital Agreement with PLAN;

WHEREAS, PLAN and HOSPITAL intend by entering into this Agreement to make available affordable, quality health-care services to enrollees in PLAN's PPO product, enrollees of other PPOs with which PLAN is or may become affiliated, and enrollees of other PPO arrangements which PLAN may administer on behalf of self-insured employers.

WHEREAS, PLAN and HOSPITAL are both committed to the delivery of quality health care services in an efficient and effective manner, recognizing the need to control and improve health care delivery; and

WHEREAS, this Agreement is intended to implement such a relationship between PLAN and HOSPITAL;

NOW, THEREFORE, in consideration of the mutual covenants and agreements herein contained, the PLAN and HOSPITAL agree as follows:

RECEIVED
MAY 29 1998
PROVIDER SERVICES

ARTICLE I
DEFINITIONS

1.1 **Appropriate Setting** - The location or type of provider capable of providing required quality medical services to a PPO Covered Person in the most cost-efficient manner as determined by the PLAN.

1.2 **Coinsurance** - The percent of the bill which a PPO Covered Person must pay for Covered Services as set forth in a PPO Membership Agreement.

1.3 **Coordination of Benefits (also referred to as "COB")** - The combining of benefits under a PLAN PPO Membership Agreement with duplicate coverage under another health insurance policy such that total benefits paid for PPO Covered Services rendered to a PPO Covered Person do not exceed the amount the PLAN would have paid under the terms of this Agreement had PLAN been the primary payor.

1.4 **Hospital PPO Application** - The document submitted to PLAN by a hospital which is desirous of becoming a PPO hospital provider.

1.5 **Hospital PPO Payment Rate** - A prospectively agreed upon amount which HOSPITAL accepts as payment from PLAN for Eligible Services provided to PPO Covered Persons.

1.6 **Hospital Service(s)** - Those acute inpatient and outpatient services which a hospital is licensed by the State of Georgia to provide.

1.7 **Medically Necessary** - Services or supplies provided by a hospital, physician, or other provider to identify or treat an illness or injury and which, as determined by PLAN, are:

- Consistent with the symptom or diagnosis and treatment of the condition, disease, ailment or injury;
- Appropriate with regard to standards of good medical practice;
- The most appropriate supply or level of service which can be safely provided to the PPO Covered Person. When applied to an inpatient, it further means that the PPO Covered Person's medical symptoms or conditions require that the services or supplies cannot be safely provided to the PPO Covered Person as an outpatient.

1.8 **Non-Covered Service** - All health-care services rendered to a PPO Covered Person other than Covered Services.

1.9 **PPO Covered Group** - Any group for which the PLAN provides or administers health-care benefits under the terms of a PPO Membership Agreement, and shall specifically include (without limiting the generality of the foregoing) a group covered or administered by another PPO with which PLAN is affiliated.

1.10 **PPO Covered Person** - An individual for whom the PLAN provides or administers health-care benefits under the terms of a PPO Membership Agreement, and shall specifically include (without limiting the generality of the foregoing) an individual covered by or enrolled with another PPO with which PLAN is affiliated.

1.11 **PPO Covered Service(s) (Also referred to as Covered Service(s))** - Those health-care services and supplies included as stated benefits in a PPO Membership Agreement.

1.12 **PPO Eligible Service(s)(Also referred to as Eligible Service(s))** - Those health-care services reimbursable under the terms of a PPO Membership Agreement which are determined by PLAN to be medically necessary and appropriate.

1.13 **PPO Hospital** - A facility licensed by the State of Georgia as a hospital, which meets PLAN PPO Hospital Criteria and has been selected by PLAN for participation in its Preferred Provider Organization, and that has agreed to the terms and conditions of PLAN's "Hospital Agreement for Preferred Provider Program".

1.14 **PPO Hospital Network** - The collection of PPO Hospitals designated by PLAN to provide hospital services to PPO Covered Persons.

1.15 **PPO Membership Agreement** - The contract between the PLAN or other Blue Cross and Blue Shield Plans and an employer, group, or individual to provide, indemnify for or administer, the delivery of health-care benefits through a preferred provider organization.

1.16 **PPO Physician** - Any physician licensed in the State of Georgia who meets PLAN's criteria to become a PPO Physician and has signed PLAN's PPO Physician Provider Agreement.

1.17 **PPO Provider Network** - The collection of health-care organizations and individual health-care or medical practitioners selected by PLAN to provide PPO Covered Services to PPO Covered Groups or Persons.

1.18 **Preferred Provider Organization (PPO)** - An alternative delivery system operated by the PLAN which is comprised of a PPO Provider Network which has agreed to obtain or provide covered, necessary, health-care services at a reduced rate of payment.

1.19 **Quality Assessment Program (also referred to as "QA Program")** - A program operated by PLAN for the collection and analysis of quantitative and qualitative data which identify patterns of health-care delivery producing the most beneficial outcome for the patient, given the patient's medical condition before, during and following medical intervention.

1.20 **Utilization Review Program (also referred to as "UR Program")** - A function performed by PLAN to review and determine whether Hospital Services provided are medically necessary, appropriate, and covered under an appropriate PPO Covered Person's Membership Agreement.

ARTICLE II
HOSPITAL SERVICES AND RESPONSIBILITIES

2.1 HOSPITAL shall provide to PPO Covered Persons PPO Eligible Services which are Medically Necessary in accordance with this Agreement, when such services are ordered by a licensed physician or other licensed health professional.

2.2 HOSPITAL shall provide PPO Eligible Services to PPO Covered Persons in the same manner and quality as those provided to all other patients of HOSPITAL.

2.3 HOSPITAL agrees to accept PLAN's payments, as provided in this Agreement, as payment in full for Eligible Services provided to PPO Covered Persons. HOSPITAL may bill PPO Covered Persons for hospital services rendered that are not PPO Covered Services, applicable deductibles or Coinsurance amounts provided in the PPO Covered Person's PPO Membership Agreement, and Eligible Services provided subsequent to PLAN providing HOSPITAL formal notification that it will not accept financial liability for such services and PPO Covered Person's acceptance of financial responsibility as indicated by the PPO Covered Person executing the appropriate form, said form to be provided to HOSPITAL by PLAN. Without limiting the foregoing, HOSPITAL agrees not to bill PPO Covered Persons for any charge discount amount provided to PLAN.

2.4 HOSPITAL has, and shall maintain in good standing: (a) all licenses required by law, (b) accreditation by the JCAHO or certification for participation in the Medicare program, (c) compliance with PLAN's PPO standards, and (d) adequate malpractice and liability insurance or sufficient restricted reserves in lieu of insurance. Further, HOSPITAL agrees that it will continue to meet PLAN's PPO Hospital Provider criteria for such time as this Agreement is in effect as between HOSPITAL and PLAN.

2.5 HOSPITAL has entered into and will maintain during the Term of this Agreement a Participating Hospital Agreement with PLAN. Further, HOSPITAL shall display in a prominent location in its admission lobby, the symbol of its PLAN PPO participation in the form provided by PLAN.

2.6 HOSPITAL shall notify PLAN immediately of:

a) Any change or notification of possible change in its state licensure, accreditation status by the JCAHO or Medicare Certification;

b) Changes in its ownership or business address; and

c) Legal or governmental action, other problem or situation which might impair the ability of HOSPITAL to carry out its duties and obligations under this Agreement, including but not limited to employee strikes or walkouts, financial insolvency, or damage to the physical plant resulting in any interruption in medical services.

2.7 HOSPITAL agrees to provide to PLAN ninety (90) days written notification of HOSPITAL intention to add, limit or delete any facility or major service identified in Exhibit A of this Agreement or the Services Inventory submitted in HOSPITAL's initial PPO Application. In the event of the addition of a service, notification shall include the proposed fees or charges for said service. PLAN shall notify HOSPITAL within forty-five (45) days of receipt of notice whether the new facility or major service will be included under the terms of this Agreement. Where HOSPITAL proposes to limit or delete a facility or major service, PLAN at its sole discretion will determine the effect of such limitation or deletion upon the HOSPITAL's continued ability to provide the required scope of hospital services to PPO Covered Persons residing within the PPO Service Area. Where PLAN determines that such limitation or deletion would adversely impact PPO Covered Persons' access to hospital services within HOSPITAL's PPO Service Area, PLAN reserves the right to cancel the Agreement subject to the termination requirements of this Agreement. PLAN will notify HOSPITAL of its determination within forty-five (45) days of receipt of notification from HOSPITAL.

2.8 HOSPITAL agrees that payments by PLAN for Eligible Services rendered to a PPO Covered Person shall be in lieu of payment or reimbursement for such hospital services under any other agreement between PLAN and HOSPITAL. Any other such agreement shall remain otherwise unaffected by this Agreement and in case of any conflict between this Agreement and any other agreement between HOSPITAL and PLAN, this Agreement shall control for matters relating to PLAN's PPO.

2.9 HOSPITAL agrees that the amount to be paid by PLAN for Eligible Services provided to PPO Covered Persons shall be less than or equal to the lowest amount HOSPITAL accepts for the same or similar Eligible Services under the terms of any funding arrangement (excluding Medicare, Medicaid, or other Agreements with PLAN or its subsidiaries) during such time as this Agreement is in force. In the event that following the execution date of this Agreement HOSPITAL enters into an arrangement whereby HOSPITAL agrees to accept less for Eligible Services than is set forth in this Agreement, HOSPITAL agrees to notify PLAN, in writing, of the terms and conditions within thirty (30) days of the effective date of said arrangement. PLAN shall, no later than thirty (30) days after receipt of such notice, notify HOSPITAL in writing as to whether it will accept the terms and conditions. If accepted by PLAN, this Agreement shall be amended with respect to the payment provisions provided herein effective for Eligible Services provided by HOSPITAL to PPO Covered Persons as of the first day of the month following the date of acceptance by the PLAN. In the event HOSPITAL fails to notify PLAN of any such contractual arrangement, PLAN shall have the right to recover from HOSPITAL the difference between its payment and the amount the PLAN would have paid under the terms of the said HOSPITAL arrangement from the effective date of said acceptance to the date of discovery, plus any legal and administrative costs incurred by PLAN associated with such recovery.

2.10 HOSPITAL agrees to take reasonable steps to ensure that members of its medical staff, health professionals working within HOSPITAL, and HOSPITAL's employees are at all times appropriately licensed, credentialed, or certified by the State of Georgia or the appropriate professional organization to perform their usual role

within HOSPITAL. HOSPITAL further agrees to cooperate with PLAN in monitoring the care provided by members of its medical staff who are PPO physician providers by notifying PLAN, by telephone, within one (1) working day of any disciplinary action (suspension, revocation, other form of reduction in privileges, or resignation in lieu of disciplinary action) taken by HOSPITAL's medical staff, its board of directors or hospital authority, or administration, or to so notify PLAN when it becomes aware of any sanction or corrective action applied to a PPO physician who is a member of its medical staff by any other hospital or agency of the state or federal government. **NOTE:** A temporary suspension of a PPO physician's admitting privileges due to untimely completion of medical records is exempted from reporting.

2.11 HOSPITAL agrees to permit PLAN to conduct hospital bill audits and Utilization Review Program audits. HOSPITAL agrees to permit such other activities as are deemed necessary by PLAN to ensure correct payment to HOSPITAL for PPO Eligible Services rendered to PPO Covered Persons.

2.12 Upon request from PLAN, HOSPITAL agrees to provide to PLAN photostatic copies of its state license; certificates of liability and malpractice insurance (for self-insured hospitals, verification from an independent, third-party as to the adequacy of funded reserves); documentation supporting that HOSPITAL remains accredited by the JCAHO or is certified for participation in the Medicare Program, copies of its most recent audited financial statements, and such other information as PLAN may require to verify that HOSPITAL continues to meet PLAN's PPO criteria.

2.13 HOSPITAL agrees that PLAN retains the right to change, revise, modify or alter the form and content of any PPO Membership Agreement without prior approval or notice to HOSPITAL.

2.14 HOSPITAL hereby expressly acknowledges its understanding that this Agreement constitutes a contract between HOSPITAL and PLAN, that PLAN is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting PLAN to use the Blue Cross and Blue Shield service marks in the state of Georgia, and that PLAN is not contracting as an agent of the Association. HOSPITAL further acknowledges and agrees that it has not entered into this Agreement based upon the representations by any person other than the PLAN and that no person, entity, or organization other than the PLAN shall be held accountable or liable to HOSPITAL for any of the PLAN's obligations to HOSPITAL created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of the PLAN other than those obligations created under other provisions of this Agreement.

ARTICLE III
PLAN SERVICES AND RESPONSIBILITIES

3.1 PLAN agrees to compensate HOSPITAL directly for PPO Eligible Services which HOSPITAL performs for PPO Covered Persons pursuant to the provisions of this Agreement.

3.2 PLAN shall make payments to HOSPITAL under this Agreement within fifteen (15) working days of receipt of bills (either paper claims or the PLAN paperless claims entry system) from HOSPITAL, provided that such bills are accurate, complete, properly itemized and clearly for medically necessary and appropriate PPO Eligible Services.

3.3 PLAN agrees to furnish to HOSPITAL PLAN's best available information regarding PPO Covered Person eligibility for PPO Covered Services and basic coverage. Such information will normally be available only for locally enrolled PPO Covered Persons and will be obtained from existing PLAN records which are available in the ordinary course of business to PLAN computer terminals. The information may be transmitted to HOSPITAL by electronic means or communicated by telephone. It is recognized by the PARTIES that circumstances inherent in the record keeping system or circumstances beyond the control of PLAN may occasionally cause retroactive changes in reported PPO Covered Person eligibility status and coverage. It is recognized by the PARTIES that final benefit adjudication verification is subject to and conditioned on the terms and conditions of the PPO Covered Person's PPO Membership Agreement including without limitation, eligibility, waiting periods, exclusions, medical waivers or riders, deductibles, coinsurance or other contract limitations, the application of which cannot be determined prior to claims submission. The verification of eligibility status and coverage is not to be viewed as an assurance or guarantee of coverage or payment.

3.4 Without limiting Paragraph 3.3, PLAN agrees that in the event its employees or agents erroneously verify a PPO Covered Person's eligibility status or coverage when information available to PLAN's employees or agents at the time of verification clearly indicates that the PPO Covered Person was not eligible or coverage did not exist, PLAN agrees to make payment to HOSPITAL for Eligible Services provided to PPO Covered Person until such time as PLAN informs HOSPITAL of its error. PLAN shall not have financial liability for any services provided subsequent to notification of HOSPITAL by PLAN that eligibility or coverage does not exist.

3.5 For such period of time as this Agreement is in effect, PLAN agrees to grant HOSPITAL the status of "PPO Hospital", to identify HOSPITAL as a PPO Hospital on information materials furnished to PPO Covered Persons and to encourage and provide incentives for such PPO Covered Persons to utilize the services of PPO Hospitals.

3.6 A PPO Covered Group may require PLAN to add and delete hospitals to or from the PLAN's PPO Hospital Network for the purposes of PPO Covered Persons enrolled under the Covered Group's PPO contract with PLAN. In the event that HOSPITAL is

so deleted, HOSPITAL shall not have the status of PPO Hospital for the deleting Covered Group and PLAN shall reimburse HOSPITAL for PPO hospital services provided to such Group's PPO Covered Persons on the same basis as provided under the terms of the Participating Hospital Agreement then in effect between HOSPITAL and PLAN.

3.7 PLAN agrees to provide HOSPITAL with the names of PPO groups on an annual basis and, from time to time, the name of any group(s) which has deleted HOSPITAL from its specific PPO benefit program.

3.8 PLAN agrees to provide HOSPITAL with a list of all providers which comprise the PPO network.

3.9 PLAN agrees to provide HOSPITAL periodic reports as PLAN may develop from time to time with regard to PPO Eligible Services provided to PPO Covered Person by Hospital.

3.10 PLAN agrees to provide appropriate identification cards to PPO Covered Persons identifying them as participants in the PPO.

ARTICLE IV
COMPENSATION AND BILLING

4.1 PLAN shall pay HOSPITAL for the provision of medically necessary and appropriate PPO Eligible Services rendered to PPO Covered Persons in accordance with the provisions of this Agreement and Appendix A which are attached to and made a part of this Agreement. The payment from PLAN shall be limited to the amounts referred to in this Agreement and Appendix A attached hereto, less deductible and Coinsurance amounts and amounts received from sources other than PLAN pursuant to the Coordination of Benefits provisions (hereinafter referred to as "COB") of a particular PPO Membership Agreement.

4.2 HOSPITAL agrees that the only charges for which PPO Covered Persons may be liable and be billed by HOSPITAL shall be for hospital services that are not PPO Covered Services, for deductibles and co-insurance as provided in the PPO Membership Agreement, and for those hospital services for which the PPO Covered Person has agreed to pay pursuant to the notification requirements of the PPO Utilization Review Program set forth in Appendix C of this Agreement.

4.3 Charges for services rendered to PPO Covered Persons shall not exceed HOSPITAL's regular billed charges made to persons other than PPO Covered Persons for the same services. If multiple charge schedules are maintained by HOSPITAL, the one which generates the lowest aggregate charge per case shall be used for PPO Covered Persons.

4.4 HOSPITAL agrees that charges submitted for Eligible Service(s) provided to a PPO Covered Person in an outpatient setting will not exceed the charge(s) that would

have been submitted had the same service(s) been provided by HOSPITAL in an inpatient setting.

4.5 The PPO Hospital Payment Rate for Inpatient and Outpatient Eligible Services provided to PPO Covered Persons shall include payment of those physician services listed in Appendix B, attached to and made part of this Agreement.

4.6 PLAN shall be permitted to recover from HOSPITAL amounts due PLAN because of (a) payments made in error, (b) the Utilization Review Program, (c) hospital audits, or (d) inaccurate payments including payments based upon erroneous or incomplete information provided by HOSPITAL. HOSPITAL first shall be given the opportunity to refund to PLAN any overpayments or payments made in error. If recovery is not received by PLAN within forty-five (45) calendar days of the date of notice from PLAN, PLAN shall have the right to offset, deducting from future payments to HOSPITAL, amounts due to PLAN. The PLAN shall provide adequate notice to HOSPITAL of any amounts offset.

4.7 PLAN shall make refunds to HOSPITAL for amounts due HOSPITAL because of omissions and underpayments of claims made in error by PLAN.

4.8 PLAN shall determine the appropriate amount of deductibles and Coinsurance to be paid by PPO Covered Persons on the basis of HOSPITAL's inpatient per diem payment rates, or eligible outpatient charges less the applicable percentage discount, as set forth in Appendix A of this Agreement. Plan shall pay only those amounts, if any, which, when added to the deductibles and coinsurance due HOSPITAL from the PPO Covered Person, and COB amount as provided in Paragraph 4.9, equal one hundred percent (100.00%) of the amount of HOSPITAL's allowable charges pursuant to this Agreement and Appendix A.

4.9 Payments for PPO claims for which PLAN had other than primary liability under the COB provisions of a particular PPO Membership Agreement, shall be limited to that amount, if any, which when added to amounts payable to HOSPITAL by all other sources, pursuant to applicable COB rules, equals one hundred percent (100.0%) of the amount which HOSPITAL would have been paid had PLAN had primary liability pursuant to this Agreement.

4.10 HOSPITAL shall bill PLAN in a manner and on forms acceptable to PLAN (currently UB-92 paper claim form or the PLAN paperless claims entry system) and on a periodic basis as prescribed by the PLAN. HOSPITAL shall furnish, on request, all information reasonably required by PLAN, including but not limited to the detailed bill, medical record, and current charge master, to verify and substantiate the provisions of PPO Eligible Services and the charges for such PPO Covered Services. PLAN reserves the right to review any and all statements submitted by HOSPITAL.

4.11 HOSPITAL shall use its best efforts to submit all bills for Eligible Services provided to PPO Covered Persons within sixty (60) days after the services are rendered, but in no instance may the bill be submitted later than twelve (12) months from the date services are rendered. Claims which are not submitted within the twelve (12) month filing period will not be honored and HOSPITAL agrees not to bill PPO

Covered Persons or PLAN for services associated with such claims. PLAN will not apply this provision to any claim in which PLAN was the cause of delay.

4.12 HOSPITAL shall submit only one claim per admission for PPO Eligible Services provided to PPO Covered Persons and only after all charges and credits have been recorded on the claim. Such claims must include charges from any another hospital or facility for specific care or treatment when transported thereto from HOSPITAL because such services were not available in HOSPITAL. The entire claim must be billed and processed at one time; therefore, HOSPITAL agrees not to bill portions of a claim whether on an interim cycle billing basis or split over the end of a calendar or fiscal year. **(EXCEPTION: HOSPITAL may submit an interim bill for inpatient services provided to a PPO Covered Person for every thirty (30) days of continuous inpatient hospitalization during the same admission).** HOSPITAL agrees that it will not attempt to collect from PLAN or a PPO Covered Person for PPO Eligible Services not included in the claim as submitted to PLAN.

4.13 In the case of an obstetrical admission, HOSPITAL shall submit a single claim for PPO Eligible Services provided to a PPO Covered Person and her newborn. However, in the event that the newborn required intensive care or remained at HOSPITAL beyond the date of the mother's discharge, HOSPITAL shall submit a separate claim for PPO Eligible Services rendered to the newborn. **EXCEPTION: From time to time PLAN's PPO may include PPO Covered Groups which require a separate claim for the mother and newborn regardless of whether the newborn required intensive care or remained in the hospital beyond the date of the mother's discharge. PLAN shall provide to HOSPITAL the names of any such PPO Covered Group and such other information as may be necessary for HOSPITAL to meet the PPO Covered Group's requirements.**

ARTICLE V
UTILIZATION REVIEW

5.1 HOSPITAL shall cooperate with and be bound by the PLAN PPO Utilization Review Program (hereinafter referred to as "UR Program") as set forth in this Article V and at Appendix C of this Agreement which is applicable to Inpatient and Outpatient Services rendered by HOSPITAL to PPO Covered Persons. HOSPITAL and PLAN agree that the terms and conditions of this Article V and Appendix C shall apply to PPO Covered Persons enrolled in PLAN's PPO.

5.2 HOSPITAL agrees to cooperate with and be bound by the terms and conditions of utilization review programs of such other PPOs with which PLAN is, or may become affiliated (e.g., Blue Cross and Blue Shield Association's Preferred Care USA) and PPO-arrangements which PLAN may administer on behalf of self-insured employers. PLAN agrees to provide to HOSPITAL a listing of all such PPOs and all information HOSPITAL may require in order to meet the utilization review terms and conditions.

5.3 HOSPITAL agrees to work with PLAN in providing case management services to selected PPO Covered Persons admitted to HOSPITAL. In collaboration with the attending physician, the PPO Covered Group and the patient or patient's family

member, PLAN shall identify appropriate, alternative treatment settings at the time of admission or during concurrent review for those admissions which require an extended period of treatment. HOSPITAL agrees that PLAN shall have reasonable access to all medical information and the assistance of HOSPITAL personnel to provide case management services.

5.4 HOSPITAL understands and agrees that the responsibility for obtaining the appropriate reviews from PLAN for hospital services for PPO Covered Persons, as set forth in Appendix C of this Agreement, shall rest with HOSPITAL.

5.5 Failure by HOSPITAL to obtain the necessary reviews as provided for in Appendix C of this Agreement shall result in a reduction in payment to HOSPITAL for PPO Eligible Services in accordance with the terms and conditions of the PPO Covered Person's PPO Membership Agreement.

5.6 HOSPITAL and PLAN recognize and agree that the pre-admission and concurrent review of Inpatient hospital services and Outpatient review approval requirements provided for in Appendix C of this Agreement are based upon medical necessity and appropriateness. Final benefit adjudication will be subject to and conditioned on the terms and conditions of the PPO Covered Person's PPO Membership Agreement including without limitation, eligibility, waiting periods, exclusions, medical waivers or riders, deductibles, coinsurance or other contract limitations, the application of which cannot be determined prior to claims submission. Pre-admission and concurrent review of Inpatient hospital services and Outpatient review approval is not to be viewed as an assurance of payment.

5.7 PLAN reserves the right to review any PPO claim for Medical Necessity, Appropriateness, and/or to determine that services provided are Eligible Services under the terms of the PPO Covered Person's PPO Membership Agreement prior to payment. PLAN shall deduct from payment to HOSPITAL the amount(s) associated with services determined to be not medically necessary, not appropriate, or not eligible. PLAN agrees to provide notification to HOSPITAL of any such determination.

5.8 HOSPITAL expressly agrees that the cost to HOSPITAL arising out of its participation in the UR Program is included in the compensation provisions of this Agreement, and that HOSPITAL will not bill either the PLAN or PPO Covered Persons for fees or charges incident to HOSPITAL's obligations under the terms and conditions of this Article.

5.9 HOSPITAL agrees not to bill a PPO Covered Person for any unpaid charges or any monies refunded to PLAN by HOSPITAL that arise out of HOSPITAL's failure to secure pre-admission or concurrent review for inpatient hospitalization; outpatient review for diagnostic procedures or treatment; or, denial of payment due to the lack of Medical Necessity, Appropriateness, or Service Eligibility.

ARTICLE VI
QUALITY ASSESSMENT PROGRAM

6.1 HOSPITAL agrees to cooperate and participate with PLAN in the development, implementation and ongoing operation of a PPO Quality Assessment (hereinafter referred to as "QA") Program.

6.2 HOSPITAL and PLAN mutually agree that the purpose of a QA Program shall be the collection and analyses of quantitative and qualitative data which identify patterns of health-care delivery producing the most beneficial and cost-effective outcome for the patient, given the patient's medical condition before, during and following medical intervention.

6.3 PLAN expressly agrees that all QA data provided to PLAN by HOSPITAL will be treated by PLAN in the same manner as it treats its own confidential business information and that any voluntary reporting of such data by PLAN shall be in a format so as not to disclose the identity of HOSPITAL, physician or patient.

6.4 HOSPITAL agrees to provide to PLAN summary QA data in a format and time schedule prescribed by PLAN.

6.5 PLAN agrees to provide to HOSPITAL comparative QA reports in a format and time schedule as PLAN may develop.

ARTICLE VII
RECORDS MAINTENANCE, AVAILABILITY, INSPECTION AND AUDIT

7.1 HOSPITAL shall prepare and maintain all appropriate records on PPO Covered Persons receiving Hospital Services at HOSPITAL. The records shall be maintained in accordance with prudent record-keeping procedures and as required by law.

7.2 Ownership and access to HOSPITAL's records of PPO Covered Persons shall be controlled by applicable federal, state and local laws, this Agreement, and any applicable privacy and confidentiality requirements.

7.3 HOSPITAL agrees to allow PLAN to inspect, audit and duplicate any and all information, including but not limited to billing, payment assignment, utilization review, and medical records maintained by HOSPITAL on PPO Covered Persons pursuant to this Agreement with the understanding that each PPO Covered Person has waived any provision of law forbidding such disclosure as a condition of enrollment as a PPO Covered Person. Such inspection, audit and duplication shall be allowed upon reasonable notice to HOSPITAL by PLAN during HOSPITAL's normal business hours, and shall be provided without cost to PLAN or PPO Covered Persons.

7.4 HOSPITAL and PLAN agree to treat any and all records required to be prepared or maintained by this Agreement in the same manner as they do their own confidential

information and agree to take all reasonable precautions to prevent the unauthorized disclosure of such records.

7.5 Subject to all applicable privacy and confidentiality requirements, medical records of PPO Covered Persons shall be made available by HOSPITAL, without cost, for Utilization Review by PLAN.

ARTICLE VIII
LIABILITY, INDEMNITY AND INSURANCE

8.1 Neither the PLAN nor HOSPITAL, nor any of their respective agents or employees shall be liable to third parties for any act or omission of the other party.

8.2 HOSPITAL agrees to indemnify and hold the PLAN harmless from any and all liability, loss, damage, claim or expense of any kind, including costs and attorney's fees, which result from any action or procedure involving alleged medical liability by HOSPITAL, its agents or employees, or which results from negligent or willful acts or omissions by HOSPITAL, its agents or employees regarding the duties and obligations of HOSPITAL under this Agreement, including the duty to maintain the legal standard of care applicable to HOSPITAL. Such indemnification and holding harmless shall not apply to any matters resulting, in whole or in part, from negligent or willful acts or omissions of PLAN or its agents or employees.

8.3 HOSPITAL, at its sole expense, agrees to maintain insurance for professional liability, and shall maintain comprehensive general liability, and such other insurance as shall be necessary to insure HOSPITAL and its employees against any and all damages arising from the duties and obligations of this Agreement or that would impair the ability of HOSPITAL to carry out the term of this Agreement; or shall provide other insurance arrangements satisfactory to PLAN. Such other arrangements will be deemed satisfactory to PLAN upon receipt by PLAN of the statement described in the last sentence of Paragraph 8.4 of this Agreement.

8.4 HOSPITAL agrees to provide to PLAN on an annual basis copies of all certificates of insurance required by this Agreement and shall provide evidence of ability to meet any other requirement of this Article. In the event that HOSPITAL reserves funds to meet the insurance requirements of this Agreement, either in part or total, HOSPITAL agrees to provide PLAN with a statement from its independent auditor, consultant or other independent, qualified expert attesting to the adequacy of such reserves.

ARTICLE IX
MARKETING, ADVERTISING AND PUBLICITY

9.1 The PLAN shall use its best efforts to encourage PPO Covered Persons to use the services of HOSPITAL.

9.2 The PLAN shall have the right to use the name of HOSPITAL for purposes of marketing, informing PPO Covered Persons of the identity of PPO Hospitals, and otherwise to carry out the terms of this Agreement.

9.3 Except as provided in Paragraph 9.2, PLAN and HOSPITAL each reserves the right and control of the use of its name, symbols, trademarks and service marks presently existing or later established. In addition, except as provided in Section 9.2, neither PLAN nor HOSPITAL shall use the other party's name, symbols, trademarks or service marks in advertising or promotional material or otherwise without the prior written consent of that party and shall cease any such usage immediately upon written notice of that party or upon termination of this Agreement, whichever is sooner.

ARTICLE X
DISPUTE RESOLUTION

10.1 PLAN and HOSPITAL agree to meet and confer in good faith to resolve any problems or disputes that may arise under this Agreement.

10.2 In the event that any problem or dispute is not satisfactorily resolved, other than a Utilization Review Program decision provided for in Article V and Appendix C, PLAN and HOSPITAL agree to arbitrate such problem or dispute; provided that before any arbitration shall be initiated the problem or dispute shall first be submitted to the Hospital Service Committee of the Board of Directors of PLAN for consideration and possible resolution. Such arbitration shall be initiated by either party making a written demand for arbitration on the other party within thirty (30) days of receipt by both parties of the proposed resolution by Hospital Service Committee. Within thirty (30) days of that demand, the PLAN and HOSPITAL shall each designate an arbitrator and give written notice of such designation to the other. Within thirty (30) days after these notices have been given, the two arbitrators selected by this process shall select a third neutral arbitrator and give notice of the selection to PLAN and HOSPITAL. The three arbitrators shall hold a hearing and decide the matter within sixty (60) days thereafter.

10.3 The arbitration shall be conducted pursuant to the rules of the American Arbitration Society. HOSPITAL and PLAN agree that the arbitration results shall be binding on both parties in any subsequent litigation or other dispute.

10.4 PLAN and HOSPITAL agree that the losing party shall be responsible for the cost of arbitration.

ARTICLE XI
TERM AND TERMINATION

11.1 When executed by both parties, this Agreement shall become effective as of the date noted on page 1 and shall continue in effect for two (2) years unless canceled by either PARTY as provided in this Article XI. Following completion of the initial

term, this Agreement may be renewed by PLAN for additional one year terms. The HOSPITAL's PPO Payment Rate set forth in Appendix A shall be effective for the period listed therein.

11.2 Notwithstanding any provision set forth herein, either party may terminate this Agreement at any time, with or without cause, by giving at least ninety (90) days written notice prior to the effective date of termination. Nothing contained in this Agreement shall be construed to limit either party's lawful remedies in the event of a material breach of this Agreement.

11.3 PLAN may suspend or terminate this Agreement immediately with cause. Suspension or termination with cause may result from, but is not limited to, the following actions or omissions by HOSPITAL: failure to continue to meet PLAN's credentialing criteria; misrepresentation of information on the application; submission of charges for services not rendered; falsely billing for services or repeatedly mis-identifying actual services performed; inappropriate conduct toward patients; quality of care issues; and interference with other programs of PLAN, its subsidiaries or affiliates.

11.4 If this Agreement is terminated pursuant to this Article XI, HOSPITAL shall continue to provide hospital services under the terms of this Agreement to PPO Covered Persons who are hospital inpatients on the date of termination until those PPO Covered Persons are discharged.

11.5 Notwithstanding termination and without cost to PLAN, PLAN shall continue to have access to records for three (3) years in accordance with Article VII, to the extent permitted by law and as necessary to fulfill the terms of this Agreement.

11.6 After the effective date of termination, this Agreement shall remain in effect for the resolution of all matters unresolved on the date of termination.

11.7 This Agreement shall automatically terminate upon the suspension or revocation of HOSPITAL's license to operate, loss of JCAHO Accreditation or certification for participation in the Medicare program, or change in ownership of HOSPITAL.

ARTICLE XII
UNFORESEEN CIRCUMSTANCES

12.1 In the event that the operations of HOSPITAL's facilities are substantially interrupted by acts of war, fire, insurrection, labor disputes, riots, earthquakes or other acts of nature, HOSPITAL shall be relieved of its obligations only as to those affected operations and only as to those affected portions of this Agreement for the duration of such interruption.

12.2 Notwithstanding the provisions of Paragraph 12.1, in the event that the hospital services provided by HOSPITAL are substantially interrupted pursuant to an event described in Section 12.1, the PLAN shall have the right to terminate this Agreement upon thirty (30) days prior written notice to HOSPITAL. Such notice of

termination may be withdrawn if the PLAN in its judgment determines during said thirty (30) day period that the hospital services can be performed in spite of the event or because the interruption has ended.

12.3 In the event that the services provided by PLAN are substantially interrupted pursuant to an event described in Paragraph 12.1, HOSPITAL shall have the right to terminate this Agreement upon thirty (30) days prior written notice to PLAN. Such notice of termination shall be withdrawn if HOSPITAL, in its judgment, determines that PLAN services can be performed in spite of the event or because the interruption has ended.

ARTICLE XIII
MISCELLANEOUS PROVISIONS

13.1 No assignment of the rights, duties or obligations of the Agreement shall be made by HOSPITAL. Any attempted assignment in violation of this provision shall be void as to PLAN.

13.2 HOSPITAL shall not subcontract this Agreement or any portion of it without written consent of PLAN.

13.3 Waiver of a breach of any provision of this Agreement shall not be deemed a waiver of any other breach of the same or different provision.

13.4 Any notices required to be given pursuant to the terms and provisions of this Agreement shall be in writing and shall be sent by certified mail, return receipt requested, postage prepaid, to PLAN at:

PREFERRED PROVIDER ORGANIZATION (PPO)
BLUE CROSS AND BLUE SHIELD OF GEORGIA INC.
PO BOX 4445
3350 Peachtree Road, NE
Atlanta, GA. 30302-4445
Attn: Corporate Provider Services

and to HOSPITAL at the address shown on the application form submitted by HOSPITAL. The notice shall be effective on the date indicated on the return receipt.

13.5 In the event any provisions of this Agreement are rendered invalid or unenforceable by any federal statute or state law, or by any regulation duly promulgated by officers of the United States or of the State of Georgia acting in accordance with law, or declared null and void by any court of competent jurisdiction, the remainder of the provisions of this AGREEMENT shall, subject to Paragraph 13.6, remain in full force and effect.

13.6 In the event that a provision of this Agreement is rendered invalid or unenforceable or declared null and void as provided in Paragraph 13.5 and its removal has the

effect of materially altering the obligations of either party in such manner as in the judgment of the party affected, (a) will cause serious financial hardship to such party, or (b) will cause such party to act in violation of its corporate Articles or Bylaws, the party so affected shall have the right to terminate this Agreement upon thirty (30) days prior written notice to the other party. The applicable provisions of Article XI shall apply to such termination.

13.7 PLAN may amend this Agreement from time to time; such amendment shall automatically become part of this Agreement sixty (60) days after written notice of the amendment has been mailed to HOSPITAL; provided that PLAN may not amend the provisions of APPENDIX A or otherwise change rates, charges or discounts without first securing agreement of HOSPITAL to such changes. HOSPITAL may terminate this Agreement by providing written notice within thirty (30) days of receipt of such amendment with such termination to become effective at the end of the calendar month next following that during which notification is given.

13.8 The headings of Articles and sections contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

13.9 This Agreement shall be construed and enforced in accordance with the laws of the State of Georgia.

13.10 Exhibits and Appendices attached hereto are fully incorporated into and made a part of this Agreement by reference herein.

BLUE CROSS AND BLUE SHIELD OF GEORGIA

EXHIBIT A
ADDRESSES WHERE HOSPITAL SERVICES ARE PROVIDED

Provide the following information for each entry: legal and business name (if different), business address, name of person with authority to act on behalf of entity and his/her telephone number, type of facility.

APPENDIX C

Utilization Review Program

1. HOSPITAL shall participate in and be bound by the PLAN PPO Utilization Review Program (hereinafter referred to as "UR Program") applicable to Inpatient and Outpatient Services rendered by HOSPITAL to PPO Covered Persons as set forth in Article V and this Appendix C of the Agreement and to the terms and conditions of utilization review programs of such other PPOs with which PLAN is, or may become affiliated (e.g., Blue Cross and Blue Shield Association's Preferred Care USA) and PPO arrangements which PLAN may administer on behalf of self-insured employers. PLAN agrees to provide to HOSPITAL a listing of all such PPOs and all information HOSPITAL may require in order to meet the utilization review terms and conditions.

2. HOSPITAL agrees to obtain from PLAN, or its designated agent, the following for all non-emergency services proposed to be provided to all PPO Covered Persons by HOSPITAL:

   a) "Pre-Admission Review" - The review of Inpatient admission prior to the PPO Covered Person's admission or treatment by HOSPITAL to determine the appropriateness thereof and, if admission is determined to be appropriate, to approve an initial length of hospitalization.

   b) "Concurrent Review" - The review of the appropriateness of continued Inpatient hospitalization and services and supplies provided incident thereto, and if appropriate, to approve the continuation of hospitalization.

   c) "Discharge Planning" - The process of planning in advance for the continuation of appropriate health-care services for a patient's treatment or convalescence, subsequent to discharge from HOSPITAL; and

   d) "Outpatient Review" - The prospective review to determine the appropriateness of selected Outpatient diagnostic and treatment procedures as identified by PLAN and provided in writing to HOSPITAL by PLAN from time to time.

3. HOSPITAL agrees to provide to PLAN such information within the time period as PLAN may require in order to make said determinations as set forth above in Paragraph 2.

4. Obstetrical admissions or admissions for a condition arising suddenly and requiring immediate Inpatient hospitalization and treatment because of danger to the life of a PPO Covered Person are excluded from pre-admission review; however, PLAN or its designated agent must be notified of such admissions, by telephone, on the next working day following the day of the PPO Covered Person's admission to HOSPITAL.

5. HOSPITAL and PLAN recognize and agree that the review requirements of Paragraph 2 and Paragraph 3, above, are based upon medical necessity and appropriateness.

Final benefit adjudication will be subject to and conditioned on the terms and conditions of the PPO Covered Person's PPO Membership Agreement including without limitation, eligibility, waiting periods, exclusions, medical waivers or riders, deductibles, coinsurance or other contract limitations, the application of which cannot be determined prior to claims submission. Pre-admission and concurrent review of Inpatient hospital services and Outpatient review approval is not to be viewed as an assurance of payment. HOSPITAL waives any claim against PLAN based upon an initial determination by PLAN which is based upon information furnished pursuant to Paragraph 2 and Paragraph 4 of this Appendix C.

6. Failure by HOSPITAL to obtain the necessary reviews for Inpatient or Outpatient services as required by PLAN or such other PPO or organizations with which PLAN may be affiliated, shall result in a reduction in payment to HOSPITAL for Eligible Services provided to a PPO Covered Person in accordance with the terms and conditions of the PPO Covered Person's PPO Membership Agreement. HOSPITAL's continued failure to comply with the requirements of the UR Program will result in the termination of this Agreement.

7. PLAN shall deduct from payment to HOSPITAL the amount(s) associated with services determined to be not medically necessary, not appropriate, or not eligible. PLAN agrees to provide notification to HOSPITAL of any such determination.

8. PLAN reserves the right to review any PPO claim for Medical Necessity, Appropriateness, or to determine that services provided are Eligible Services prior to payment.

9. HOSPITAL agrees not to bill a PPO Covered Person for any unpaid charges or any monies refunded to PLAN by HOSPITAL that arise out of HOSPITAL's failure to secure pre-admission or concurrent review for inpatient hospitalization; outpatient review for diagnostic procedures or treatment; or, prospective or retrospective denial of payment due to the lack of Medical Necessity, Appropriateness, or a determination that a service is not an Eligible Service.

10. HOSPITAL expressly agrees that it will not bill or attempt to collect fees or charges from either PLAN or a PPO Covered Person for the cost to HOSPITAL arising out of its participation in the PLAN's PPO UR Program or such other utilization program as required by a PPO or organization with which PLAN is affiliated.

11. When PLAN determines through the UR Program that it will not accept financial liability for initial or continued inpatient hospitalization, outpatient diagnostic or treatment procedure, or when a more appropriate setting is available, PLAN shall provide notification of its determination to HOSPITAL, the Attending Physician, and the PPO Covered Person. For those cases involving continued inpatient hospitalization, the notification shall include a date after which PLAN will no longer accept financial liability for inpatient services provided by HOSPITAL to the PPO Covered Person.

12. HOSPITAL may bill a PPO Covered Person for services provided following a determination by PLAN that it will not accept financial responsibility provided that

HOSPITAL first obtains from the PPO Covered Person, or his or her financial guarantor, a signed notice of personal financial responsibility on a form to be provided by PLAN.

13. Should HOSPITAL or the PPO Covered Person's attending physician disagree with PLAN's determination not to accept financial liability for initial or continued inpatient hospitalization, outpatient diagnostic or treatment procedure, or that a more appropriate setting is available, HOSPITAL or the PPO Covered Person's attending physician may appeal PLAN's determination to the PLAN PPO Medical Director or his or her designee. Such an appeal must be made no later than the first working day following notification by PLAN of its determination. The decision of the PPO Medical Director, or designee, shall be binding on PLAN.

14. When the PLAN PPO Medical Director's, or designee's, decision upholds PLAN's initial determination, HOSPITAL or the PPO Covered Person's attending physician may request that the matter be reviewed by a PLAN physician consultant. Such request must be made no later than the next working day following PPO Medical Director's, or designee's, decision. PLAN will refer the matter to an appropriate physician consultant no later than the next working day following the request for determination review. The appeal shall be conducted by a telephone conference between the PPO Covered Person's Attending Physician and PLAN physician consultant. The decision of PLAN physician consultant shall be binding upon PLAN, HOSPITAL, Attending Physician, and the PPO Covered Person with respect to PLAN's financial liability for initial or continued inpatient hospitalization, outpatient diagnostic or treatment procedure, or that a more appropriate setting is available.

15. HOSPITAL agrees that PLAN may conduct Retrospective Reviews of Inpatient and Outpatient claims submitted to PLAN for services rendered by HOSPITAL to PPO Covered Persons. Such reviews shall be conducted for the purpose of verifying: (a) that Inpatient and Outpatient PPO Covered Services provided to PPO Covered Persons were medically necessary and delivered in the appropriate setting as documented in the medical record, (b) that Inpatient and Outpatient hospital services provided to a PPO Covered Person were Covered Services as provided in the PPO Covered Person's PPO Membership Agreement, and (c) that the information provided to PLAN by HOSPITAL for Pre-Admission, Concurrent, and Outpatient Review is documented through the medical record. PLAN shall provide to HOSPITAL a listing of PPO Covered Persons' claims selected for Retrospective Review. HOSPITAL agrees to provide PLAN photostatic copies of those elements of the PPO Covered Persons' medical record required to perform the review within fifteen (15) working days of receipt of notice from PLAN. Such copies shall be provided to PLAN without cost to PLAN or PPO Covered Person. PLAN agrees to provide HOSPITAL with a written report of its findings.

16. PLAN reserves the right to retrospectively review a larger sample of claims or all PPO claims submitted during the prior twelve (12) month period if the sample review demonstrates a pattern of deviation in that: (a) Inpatient and Outpatient PPO Eligible Services provided to PPO Covered Persons were not medically necessary or delivered in the appropriate setting as documented in the medical record,(b) Inpatient and Outpatient hospital services provided to a PPO Covered Person were

not Covered Services as provided in the PPO Covered Person's PPO Membership Agreement, or (c) the information provided to PLAN by HOSPITAL for Pre-Admission, Concurrent, and Outpatient Review is not documented through the medical record. Expanded reviews will be conducted at HOSPITAL by PLAN staff, or its designated agent, and HOSPITAL agrees to cooperate fully in the timely and efficient completion of such reviews. PLAN agrees to provide HOSPITAL with a written report of its findings.

17. HOSPITAL agrees to refund to PLAN any payments received from PLAN associated with medical services which are determined to have been not medically necessary, appropriate, or non-covered within thirty (30) days of receipt of PLAN's written findings of the retrospective review unless HOSPITAL appeals PLAN's findings as provided below at Paragraph 18.

18. HOSPITAL may appeal an adverse retrospective determination by PLAN under the provisions of Paragraph 14 and Paragraph 15, above, by providing a written request of appeal, along with three (3) copies of the complete medical record and any additional supporting documentation, to PLAN within thirty (30) calendar days of receipt of PLAN's findings from the Retrospective Review. Within five (5) working days of receipt of HOSPITAL's written request for appeal, PLAN shall provide a copy of the medical record and any additional supporting documentation to PLAN physician consultant for review. The determination of the physician consultant shall be binding upon PLAN and HOSPITAL.

19. In the event HOSPITAL appeals and the physician consultant's findings support PLAN's retrospective review, either in part or in their entirety, HOSPITAL agrees to refund to PLAN within thirty (30) days any amount paid to HOSPITAL associated with services which the physician consultant determines to have been not medically necessary, not appropriate, or non-covered. HOSPITAL further agrees that it may not bill PPO Covered Persons for those services which the PLAN determines, as a result of a retrospective review, not to have been medically necessary or not appropriate. PLAN agrees that HOSPITAL may bill PPO Covered Persons for services provided which PLAN determines to have been non-covered under the benefits of the PPO Covered Persons' PPO Membership Agreement.

AMENDMENT TO HOSPITAL AGREEMENT
FOR
PREFERRED PROVIDER ORGANIZATION PROGRAM
BETWEEN
BLUECROSS BLUESHIELD OF GEORGIA
AND
CHESTATEE REGIONAL HOSPITAL

BlueCross and BlueShield of Georgia "PLAN" and Chestatee Regional Hospital "HOSPITAL" agree that the Hospital Agreement for the Preferred Provider Organization Program (the "Agreement") is as follows:

The Agreement is for a period of one (1) year beginning ~~May 1~~ JUNE 1, 1998 and ending ~~April 30~~ MAY 31, 1999.

The PLAN and HOSPITAL agree to amend the Agreement as follows:

1) Section 2.9, is rendered, not applicable.
2) Section 8.2, shall be included:
   PLAN agrees to indemnify and hold HOSPITAL harmless for any and all liability, loss, damages, fines, demands, suits, actions, claims or expenses, including reasonable costs and attorney's fees, which shall result from negligent acts or willful acts or omissions by PLAN, its agents or employees regarding the performance of the duties and obligations of PLAN under the terms of the Agreement.
3) Section 10.3, shall include:
   The location of arbitration shall be Atlanta, GA.

All terms and conditions of the Hospital Agreement for the Preferred Provider Organization Program is in full force and effect.

Hospital	BlueCross BlueShield of Georgia, Inc.
Chestatee Regional Hospital	
Name of the Hospital	
By: Signature	By: Signature
GAYLE BRADLEY	MARK GAYTON
Name Printed	Name Printed
DIRECTOR, MANAGED CARE	VP
Title	Title
5/18/98	5/18/98
Date	Date

CHESSIGN.4/98/JBOZE

HOSPITAL AGREEMENT
FOR
PREFERRED PROVIDER ORGANIZATION PROGRAM
BETWEEN
BLUECROSS BLUESHIELD OF GEORGIA
AND

CHESTATEE REGIONAL HOSPITAL

PLAN and HOSPITAL agree that the Hospital Agreement for the Preferred Provider Organization Program (the "Agreement") is as follows:

The Agreement is for a period of one (1) year beginning ~~May 1~~ June 1, 1998 and ending ~~April 30~~ May 31, 1999.

All terms and conditions of the Hospital Agreement for the Preferred Provider Organization Program is in full force and effect.

Hospital	BlueCross BlueShield of Georgia, Inc.
Chestatee Regional Hospital	
Name of the Hospital	
By: Signature	By: Signature
GAYLE BRADLEY	MARK CLAYTON
Name Printed	Name Printed
DIRECTOR, MANAGED CARE	VP
Title	Title
5/13/98	5/18/98
Date	Date

CHESSIGN.2/98/JBOZE

BLUECROSS BLUESHIELD OF GEORGIA
PREFERRED PROVIDER ORGANIZATION
REIMBURSEMENT RATES
FOR
CHESTATEE REGIONAL HOSPITAL

1. Name of Facility: Chestatee Regional Hospital

2. Reimbursement Period: Reimbursement rates below are effective for PPO claims incurred from June 1, 1998 through May 31, 1999.

3. Inpatient Per Diem Payment Rates: Reimbursement for approved eligible inpatient services will be at the following rates:

Medical	REDACTED
Surgical	
OB Normal	
OB -Section	
Boarder Baby	
ICU/CCU/NICU	

4. Outpatient/Other Payment Rate (including but not limited to Emergency Room, Implantables, Pharmaceuticals): REDACTED of charges PPO eligible services.

5. Stop Loss: REDACTED payment for eligible PPO charges from first day of admission.

FOR BLUECROSS BLUESHIELD OF GEORGIA, INC.

BY: SIGNATURE

MARK CLAYTON
NAME PRINTED

VP
TITLE

5/18/98
DATE

HOSPITAL

CHESTATEE REGIONAL HOSPITAL
NAME OF THE HOSPITAL

BY: SIGNATURE

GAYLE BRADLEY
NAME PRINTED

DIRECTOR, MANAGED CARE
TITLE

5/13/98
DATE

CHESPPOS/98.JBOZE

BLUE CROSS AND BLUE SHIELD OF GEORGIA

PREFERRED PROVIDER ORGANIZATION

HOSPITAL AGREEMENT

FOR BLUE CROSS AND BLUE SHIELD OF GEORGIA:

(Signature)

MARK CLAYTON
(Name)

VP
(Title)

5/18/98
(Date)

FOR HOSPITAL:

CHESTATEE REGIONAL Hospital
(Name of Hospital)

(Signature)

GAYLE BRADLEY
(Name)

Director, Managed Care
(Title)

(Date)

AMENDMENT TO
HOSPITAL AGREEMENT FOR PREFERRED PROVIDER ORGANIZATION
Between
BLUE CROSS AND BLUE SHIELD OF GEORGIA
And
Chestatee Regional

Effective, March 1, 2006

Blue Cross and Blue Shield of Georgia (BCBSGa) and Chestatee Regional Hospital (HOSPITAL), parties to a BCBSGa Hospital Agreement (Agreement) dated May 18, 1998 agree as follows:

WHEREAS, BCBSGa and HOSPITAL are parties to a PPO Hospital Agreement which includes provisions relating to the rendering of outpatient radiology services by HOSPITAL, and

WHEREAS, certain claims (the "Disputed Claims" as defined below) have been disputed between BCBSGa and HOSPITAL, and

WHEREAS, the parties desire to settle the "Disputed Claims" and enter into releases in connection therewith pursuant to this Amendment.

NOW THEREFORE, the existing Attachment A, Hospital Reimbursement Rates of Agreement shall be amended as follows:

For the period of March 1, 2006 through April 30, 2006 reimbursement for approved inpatient services will be at the following rates:

Inpatient Services	**Per Diem**
Medical	REDACTED
Surgical	
ICU/CCU	
Boarder Baby	

Effective May 1, 2006 reimbursement for approved inpatient services will be at the following rates or as updated in accordance with Appendix A, Section 2.:

Inpatient Services	**Per Diem**
Medical	REDACTED
Surgical	
ICU/CCU	
Boarder Baby	

The Parties agree that these increased reimbursement rates for the period of March 1, 2006 through April 30, 2006, shall be in full settlement for all outpatient radiology services for the period of February 1, 2005 through February 28, 2006.

Performance of the obligations stated above shall release BCBSGa from further obligations with respect to the outpatient radiology claims incurred from February 1, 2005 through February 28, 2006.

To the extent conflict arises between the provisions of the Amendment and those of the Agreement, the provisions of the Amendment shall control.

Except for the above, all other terms and conditions of the Agreement remain in full force and effect.

IN WITNESS WHEREOF, the parties hereto have executed the Amendment as of the date shown on the first page hereof.

FOR BLUE CROSS BLUE SHIELD OF GEORGIA, INC.

(Signature)

Merri S. Rivers
(Printed Name)

Vice President, Network Management
(Title)

2/16/06
(Date)

FOR HOSPITAL

(Signature)

Rob Followell
(Printed Name)

CEO
(Title)

2/6/06
(Date)

Appendix A
Hospital PPO Payment Rates

1. Name of Facility: Chestatee Regional Hospital

2. Notwithstanding anything in the Agreement to the contrary the reimbursement rates below are effective March 1, 2004 and following the Initial Term shall renew automatically unless amended in writing by both parties or the Agreement is terminated in accordance with Article XI. Effective February 1, 2005 and each February 1 thereafter during the term of this Agreement, the reimbursement rates shall be adjusted by an "Index". The "Index" will be the Consumer Price Index for All Urban Consumers (CPI-U) in the Southern Region as published by the Bureau of Labor Statistics, U.S. Department of Labor, plus REDACTED REDACTED applicable to the preceding twelve (12) month period ended three (3) months prior to the date of determination. October 31.

3. Reimbursement for inpatient Covered Services provided to Covered Persons by HOSPITAL will be the lesser of HOSPITAL's charges for inpatient PPO Covered Services or the total inpatient per diem allowance based on the per diem rates specified below. Total inpatient per diem allowance will be the specified rate per day multiplied by the number of approved, eligible inpatient days for each service.

   The payment from PLAN shall be limited to the reimbursement allowance determined as described above, less deductible, coinsurance and/or copayment amounts and amounts received from sources other than PLAN pursuant to the Coordination of Benefits provision of a Membership Agreement. The Covered Person may not be billed for the difference between total billed charges and the total reimbursement allowance.

4. Inpatient Per Diem Reimbursement Rates: Reimbursement for approved inpatient services will be at the following rates:

Category	Per Diem	Category	Case Rate
Medical	REDACTED	OB Normal	REDACTED
Surgical		OB C-Section	
CCU/ICU			
Boarder Baby			

5. The reimbursement rate in effect at the time of the Covered Person's admission shall determine reimbursement to be paid to the HOSPITAL.

6. Inpatient Implants, Medical Devices, Prosthetics, Orthotics, Pacemakers and Stent(s) and Intraocular lens (Revenue Codes 274, 275, 276 and 278) will be reimbursed at HOSPITAL's invoice cost + 10%.

   Reimbursement will apply only to implantable devices specifically listed in this item 6. Any other HOSPITAL services and supplies billed with these Revenue Codes will not be eligible for reimbursement. HOSPITAL will use reasonable efforts to ensure that the charges contained within each Implant Revenue Code are appropriately categorized. PLAN may conduct an audit of the items and charges contained within each Implant Revenue Code by requesting that HOSPITAL provide the detail of charges contained therein, including the invoice (when appropriate). The objectives of the audit will be (1) to validate that the charges contained within each Implant Revenue Code were categorized appropriately and (2) to validate that the reimbursement specified above is reflective of REDACTED *Such audits will be performed and adjudicated on an account specific basis. Should PLAN and HOSPITAL agree that an error in billing has occurred, HOSPITAL agrees to determine the number of times the erroneous item was paid by PLAN and shall reimburse PLAN the agreed upon overpayment in a timely fashion.*

7. High Cost Drugs: Drugs that are covered eligible billed charges shall be excluded from the case rate/per diem reimbursement. The drugs must be submitted with the 636 Revenue Code in addition to the HCPCS code listed below:

HCPCS Code	Description
J2997	Injection, alteplase recombinant, 1 mg
P9045	Infusion, albumin (human), 5%, 250 ml
P9047	Infusion, albumin (human), 25%, 50 ml
J0585	Botulinum toxin type A, per unit
J3490 (unclassified drug)	Brevibloc, 100 mg
J1450	Injection, fluconazole, 200 mg
Q2006	Injection, digoxin immune fab (ovine), per vial
90375	Rabies immune globulin (Rlg), human, for intramuscular use
J3490 (unclassified drug)	Inocor
J9218	Leuprolide acetate, [Lupron], per 1 mg
C9114 (code deleted, use J2324)	Injection, nesiritide, 0.5 mg
J2505	Injection, pegfilgrastim, 6 mg
J1745	Injection, infliximab, 10 mg
J2993	Injection, reteplase, 18.1 mg
J3100	Injection, tenecteplase, 50 mg
J2020	Injection, linezolid, 200 mg

When the total cost per day for a specific drug listed above, exceeds REDACTED that specific drug will be reimbursed at REDACTED of AWP or the lesser of low brand or median generic from Redbook for each day that the cost for that specific drug exceeds REDACTED

Periodic updates may be made for drug codes to reflect current pricing. The rates shall be multiplied times the number of units filed on the UB-92, or applicable claim form to calculate the additional carve out reimbursement amounts. Upon ninety (90) days written notice from HOSPITAL, HOSPITAL and BCBSGA/BCBSHP will review proposed HOSPITAL additions to drug carve-out list. Provided, proposed drugs meet BCBSGA/BCBSHP coverage and utilization management criteria and are verified to cost HOSPITAL in excess of REDACTED contract will be amended to include proposed drugs.

8. Stop Loss Threshold - REDACTED The per diem will be paid through the day the Stop Loss Threshold is met. Charges above the stop loss threshold will be reimbursed at REDACTED discount off of eligible billed charges. HOSPITAL'S Stop Loss Threshold and Stop Loss discount will be adjusted in total for HOSPITAL'S price increase above the "Index" outlined in item 2. The High Cost Drugs outlined in item 7 shall be excluded from the Stop Loss Threshold.

9. Reimbursement for outpatient Covered Services provided to Covered Persons by HOSPITAL will be the lesser of HOSPITAL's charges for outpatient PPO Covered Services or the total outpatient allowance based on the rates specified below.

10. Outpatient Surgery Payment Rate: Reimbursement for approved eligible outpatient surgical services will be at the following rates:

SC 1
SC 2
SC 3
SC 4
REDACTED
SC 5
SC 6
SC 7
SC 8
REDACTED
SC 9
REDACTED

For multiple surgical procedures performed during the same operative session, the reimbursement

is as follows:

First Surgery
Second Surgery
Additional Surgery

REDACTED

Surgical Categories (SC) Groups include those procedures grouped by BSCSGA/PLAN. All outpatient procedures that are not grouped by BCBSGA/PLAN will be considered "non-groupable". A non-groupable procedure submitted alone or only with other non-groupable procedures, will be paid at a REDACTED iscount off eligible billed charges not to exceed the Maximum Outpatient Case Rate in number 15.

11. Other Outpatient Surgeries (list all by CPT Code)
These procedures are excluded from the Outpatient Discount specified in 14. below:

CPT-4 Code	Case Rate	CPT-4 Code	Case Rate
Arthroscopic	REDACTED	Cardiac	REDACTED
29805 – 29827		93501 – 93524	
29870 - 29887		93526 – 93529	
29999		93530 – 93562	
Laparoscopic			
38120		47570	
38570 – 38589		49320 – 49322	
43280		49323	
43651 - 43652		49329	
43653		49650 – 49659	
44200		58550	
44201 – 44202		58560	
44970		58562	
47562 – 47564		58660 – 58673	
Lithotripsy			
50590			

12. ER Case Rate (including any use of observation room in conjunction with the ER) will be REDACTED

Section 6.2 Network

ER Stop Loss Threshold: REDACTED The ER case rate will be paid until the threshold is met . Charges above the Stop Loss Threshold will be reimbursed at a REDACTED iscount off eligible billed charges. HOSPITAL must notify PLAN in writing of all cases which exceed the Stop Loss Threshold. *All claims that reach the threshold will need to be submitted to PLAN by HOSPITAL per instructions given by PLAN; do not bill these electronically.*

13. Radiology Technical Component REDACTED of 2003 Area 2 RBRVS Fee Schedule. The RBRVS Fee Schedule includes those procedures valued by Medicare and BCBSGA/BCSBHP. (Services not rendered as part of an inpatient day, ER case rate or an outpatient surgery reimbursement under SCs or outpatient surgery rate specified above). These CPT Codes will be updated annually for new, deleted and replacement codes. Any new or replacement code will be reimbursed at REDACTED of the Area 2 RBRVS Fee Schedule in effect at the time of the CPT Code annual update.

14. Outpatient Discount (all other outpatient services not included above not to exceed the Maximum Outpatient Case Rate in number 15) REDACTED discount off of eligible billed charges. HOSPITAL'S outpatient discount will be adjusted for HOSPITAL'S price increase above the "Index" outlined in item 2.

15. Maximum Outpatient Case Rate REDACTED (applies to services subject to outpatient discount)

16. Outpatient Implants, Medical Devices, Prosthetics, Orthotics, Pacemakers and Stent(s) [illegible] (Revenue Codes 274, 275, 276 and 278) will be reimbursed at REDACTED

Reimbursement will apply only to implantable devices specifically listed in this item 16. Any other HOSPITAL services and supplies billed with these Revenue Codes will not be eligible for reimbursement. HOSPITAL will use reasonable efforts to ensure that the charges contained within each Implant Revenue Code are appropriately categorized. PLAN may conduct an audit of the items and charges contained within each Implant Revenue Code by requesting that HOSPITAL provide the detail of charges contained therein, including the invoice (when appropriate). The objectives of the audit will be (1) to validate that the charges contained within each Implant Revenue Code were categorized appropriately and (2) to validate that the reimbursement specified above is reflective of REDACTED *Such audits will be performed and adjudicated on an account specific basis. Should PLAN and HOSPITAL agree that an error in billing has occurred, HOSPITAL agrees to determine the number of times the erroneous item was paid by PLAN and shall reimburse PLAN the agreed upon overpayment in a timely fashion.*

FOR BLUE CROSS AND BLUE SHIELD OF GEORGIA:

(Signature)

W. Vincent Barksdale
(Name)

Vice President, Network Management
(Title)

3/10/04
(Date)

FOR HOSPITAL:

(Signature)

Rob A. Pollowell
(Name)

Chief Executive Officer
(Title)

02/18/2004
(Date)

AMENDMENT
TO HOSPITAL AGREEMENT
FOR PREFERRED PROVIDER ORGANIZATION
BETWEEN
BLUE CROSS AND BLUE SHIELD OF GEORGIA, INC.
and
CHESTAEE REGIONAL HOSPITAL

EFFECTIVE August 19, 2016

WHEREAS, BLUE CROSS BLUE SHIELD OF GEORGIA, INC. ("PLAN") and SOUTHERN HEALTH CORPORATION OF DAHLONEGA d/b/a CHESTAEE REGIONAL HOSPITAL ("HOSPITAL") have previously entered into an Agreement (hereinafter referred to as the "Agreement") made and entered into on the 18 day of May, 1998; and

WHEREAS, Section 13.1 of the Agreement states:

No assignment of the rights, duties or obligations of this Agreement shall be made by HOSPITAL. Any attempted assignment in violation of this provision shall be void as to PLAN.

WHEREAS, Southern Health Corporation of Dahlonega, Inc. d/b/a Chestatee Regional Hospital("SHCD") has requested consent to assign the Agreement to Durall Capital Holdings d/b/a Chestatee Regional Hospital ("DCH") which is a newly formed entity that will utilize the hospital assets and conduct the hospital operations previously performed by SHCD and PLAN wishes to consent to the Assignment;

NOW THEREFORE, for and in consideration of the mutual promises and covenants contained in the Amendment, the receipt and sufficiency of which is hereby acknowledged, the parties hereto, intending to be legally bound, agree to modify the Agreement as follows:

PLAN hereby consents to the Assignment of the Agreement by SHCD d/b/a Chestatee Regional Hospital to DCH d/b/a Chestatee Regional Hospital, and by its execution of this Assignment, DCH d/b/a Chestatee Regional Hospital agrees to be bound by all terms and conditions of the Agreement as "HOSPITAL" therein.

Except for the above, all other terms and conditions of the Agreement remain in full force and effect. Section 13.1 shall apply to any future assignments of the rights, duties or obligations of the Agreement.

IN WITNESS WHEREOF, the parties hereto have executed the Amendment as of the date first written above.

Blue Cross and Blue Shield of Georgia, Inc.

By: Signature

Jeff Fusile
Printed Name

President
Title

8/9/2006
Date

Southern Health Corporation of Dahlonega, Inc. d/b/a Chestatee Regional Hospital

Jeanne Vangaldr
By: Signature

Jeanne Vangaldr
Printed Name

CEO
Title

9-1-16
Date

Durall Capital Holdings d/b/a Chestatee Regional Hospital

James P. Yarborough
By: Signature

James P. Yarborough
Printed Name

CEO
Title

8/31/2016
Date

Amendment to
Hospital Agreement for Preferred Provider Program
between
Blue Cross and Blue Shield of Georgia
and

Chestatee Regional Hospital

Effective November 1, 2017, PLAN and HOSPITAL agree that the Hospital Agreement for Preferred Provider Program (the "Agreement"), is amended as follows:

The Lab Fee Schedule is added to the agreement as Appendix B.

Except for the above, all other terms and conditions of the Hospital Agreement for Preferred Provider Program remain in full force and effect.

To the extent conflict arises between the provisions of the Amendment and those of the Agreement, the provisions of the Amendment shall control.

IN WITNESS WHEREOF, the parties hereto have executed the Amendment as of the date shown on the first page hereof.

BLUE CROSS AND BLUE SHIELD OF GEORGIA, INC.

(Signature)

Shalini A. R. Wittstruck
(Printed Name)

Regional Vice President, Georgia Provider Solutions
(Title)

9/26/2017
(Date)

CHESTATEE REGIONAL HOSPITAL

(Signature)

AARON DURALL
(Printed Name)

CEO
(Title)

9/22/2017
(Date)

Chestatee Regional Hospital
Appendix B
PPO Lab Fee Schedule

Lab codes not listed on Lab Fee Schedule will price at $0.00.

CPT	FAC_FEE
36415	$ REDACTED
78267	$
78268	$
80047	$
80048	$
80050	$
80051	$
80053	$
80055	$
80061	$
80069	$
80074	$
80076	$
80081	$
80150	$
80155	$
80156	$
80157	$
80158	$
80159	$
80162	$
80163	$
80164	$
80165	$
80168	$
80169	$
80170	$
80171	$
80173	$
80175	$
80176	$
80177	$
80178	$
80180	$
80183	$
80184	$
80185	$
80186	$
80188	$
80190	$

CPT	FAC_FEE
80192	$ REDACTED
80194	$
80195	$
80197	$
80198	$
80199	$
80200	$
80201	$
80202	$
80203	$
80299	$
80305	$
80306	$
80307	$
80320	$
80323	$
80324	$
80327	$
80329	$
80332	$
80335	$
80339	$
80342	$
80345	$
80346	$
80349	$
80350	$
80353	$
80354	$
80355	$
80356	$
80357	$
80358	$
80359	$
80360	$
80361	$
80362	$
80365	$
80366	$
80367	$

CPT	FAC_FEE
80368	$ REDACTED
80369	$
80371	$
80372	$
80373	$
80374	$
80375	$
80376	$
80377	$
80400	$
80402	$
80406	$
80408	$
80410	$
80412	$
80414	$
80415	$
80416	$
80417	$
80418	$
80420	$
80422	$
80424	$
80426	$
80428	$
80430	$
80432	$
80434	$
80435	$
80436	$
80438	$
80439	$
80500	$
80502	$
81000	$
81001	$
81002	$
81003	$
81005	$
81007	$

CPT	FAC_FEE
81015	$ REDACTED
81020	$
81025	$
81050	$
81161	$
81162	$
81170	$
81206	$
81207	$
81208	$
81210	$
81211	$
81212	$
81213	$
81214	$
81215	$
81217	$
81218	$
81219	$
81225	$
81226	$
81227	$
81235	$
81240	$
81241	$
81245	$
81246	$
81256	$
81261	$
81262	$
81263	$
81264	$
81265	$
81267	$
81268	$
81270	$
81272	$
81273	$
81275	$
81276	$
81287	$
81288	$
81291	$
81292	$
81293	$

CPT	FAC_FEE
81294	$ REDACTED
81295	$
81296	$
81297	$
81298	$
81299	$
81300	$
81301	$
81310	$
81311	$
81313	$
81314	$
81315	$
81316	$
81317	$
81318	$
81319	$
81321	$
81322	$
81323	$
81327	$
81332	$
81340	$
81341	$
81342	$
81370	$
81371	$
81372	$
81373	$
81374	$
81375	$
81376	$
81377	$
81378	$
81379	$
81380	$
81381	$
81382	$
81383	$
81413	$
81414	$
81422	$
81435	$
81436	$
81439	$

CPT	FAC_FEE
81445	$ REDACTED
81450	$
81519	$
81528	$
81535	$
81536	$
81539	$
82009	$
82010	$
82013	$
82016	$
82017	$
82024	$
82030	$
82040	$
82042	$
82043	$
82044	$
82045	$
82075	$
82085	$
82088	$
82103	$
82104	$
82105	$
82106	$
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